# Canadian Hospital Council

**The Federation of Hospital Associations in Canada in co-operation with the Federal and Provincial Governments and the Canadian Medical Association**

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## When every hour seems a minute

THERE is an important factor in understaffed, overworked x-ray darkrooms. Every minute saved pays big dividends in increased darkroom output.

Many an x-ray section can save valuable time—*turn out more radiographs per day*—simply by dropping old-fashioned methods of preparing processing formulas.

The answer is simple: standardize on Ansco Liquadol and Liquafix.

### TWO-WAY TIME-SAVERS

Liquadol and Liquafix are concentrated *LIQUID* formulas. You merely add water and they're ready to use.

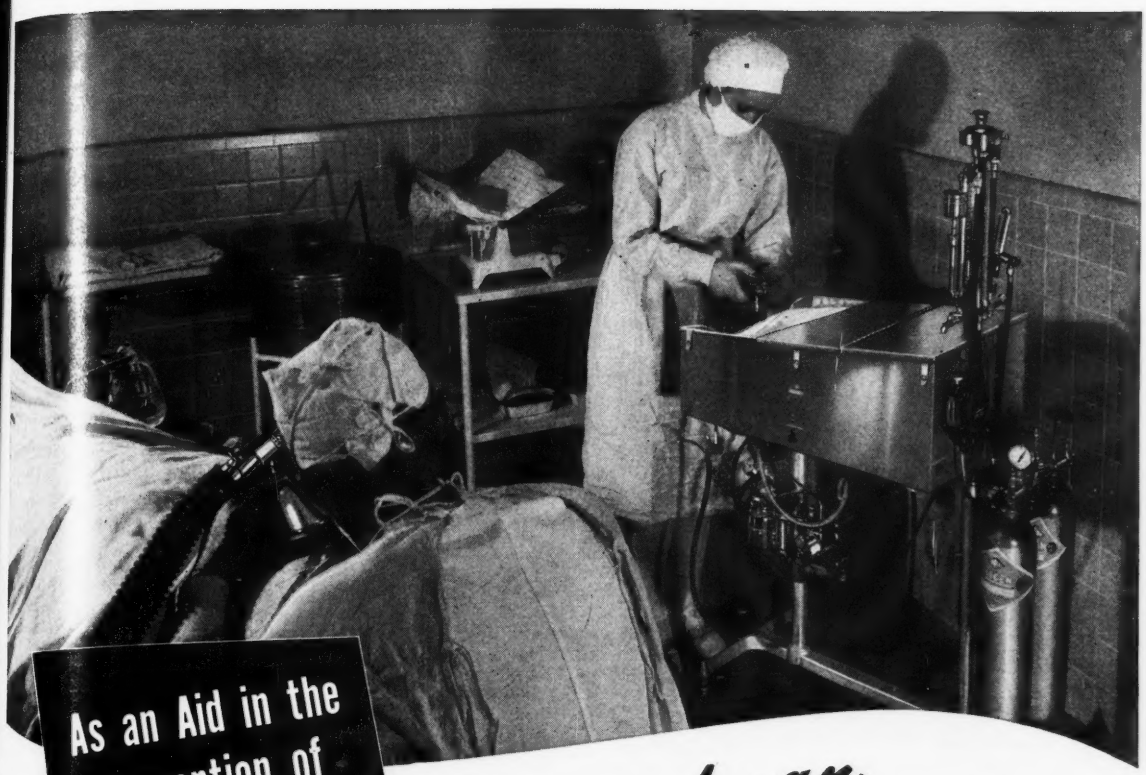
But that's not all. They save time by *acting* faster, too! Liquadol develops radiographs on Ansco High-Speed film to normal density and contrast in just *3* minutes at 68° F.!

Liquafix cuts fixing time—instead of "hypo" (sodium thiosulfate) it contains a costlier, faster-acting ingredient.

Both last and l-a-s-t in use! Liquadol, for instance, develops about 50% more films than most comparable conventional formulas. And —used or stored—keeping qualities are excellent! Try these efficient, economical time-savers. Change to Liquadol and Liquafix today!

**Ansco of Canada Limited, Toronto, Ontario.**

*Ansco*
**LIQUADOL**
**LIQUAFIX**



## As an Aid in the Prevention of Asphyxia in the Hospital . .

# *Kreiselman Resuscitators*

FOR many years Kreiselman Resuscitators have been used by leading hospitals and prominent physicians and have been proved correct in principle, efficient and simple to operate, and durable.

These resuscitators operate on a positive pressure principle and with pre-selected pressures ranging from 2 to 25 mm. mercury. (On infant models pressures range from 2 to 15 mm. mercury.) The model illustrated above is a combined resuscitator and heated bassinet thermostatically controlled. The heat is always constant and correct.

Included in the Kreiselman line are machines for adults and infants—heated bassinet models and bassinets with head tents.

*An informative 20-page booklet just published gives complete details about Kreiselman Resuscitators. This booklet will be supplied upon request, together with a copy of the reprinted article "The Treatment of Asphyxia" by Joseph Kreiselman, M.D., Consultant in Anesthesiology, George Washington University Medical School.*

OHIO

**OXYGEN COMPANY OF CANADA LIMITED**

2535 ST. JAMES STREET WEST
MONTREAL, QUEBEC

180 DUKE STREET
TORONTO, ONTARIO

*Army-Navy E and Maritime M awarded to the Heidbrink Division for production achievement.*

OXYGEN COMPANY OF CANADA LIMITED, 180 Duke Street, Toronto, Ontario

Gentlemen:
Please send 20-page booklet "Kreiselman Resuscitators and Bassinets." Also your library reprint No. 207.

NAME _____

ADDRESS _____

CITY _____ PROV. _____ CH

# Across the Desk

By C. A. E.

### Streptomycin Being Studied

A NEW drug, streptomycin, companion to penicillin as a killer of bacteria, is being studied and undergoing tests by the U.S. Army Medical Department to determine its suitability as a germ killer in saving the lives of wounded and sick soldiers.

The new drug shows possibilities which may prove to be as important to the medical profession as was the discovery of penicillin. Streptomycin is a killer of gram-negative bacteria, such as tuberculosis, cholera, dysentery, typhoid, tularemia and salmonella food poisoning. Penicillin is a killer of gram-positive bacteria, such as pneumococcus, streptococcus, staphylococcus, gonococcus and syphilis.

* * * *

### Import Subsidy for Crockery, Chinaware

Articles of china, porcelain, earthenware, stoneware or other pottery used in the preparation or serving of food or drink by hospitals, sanatoriums, hotels, restaurants and similar organizations and institutions, are eligible for subsidy consideration as long as they do not bear the crest, name or other identification mark of the user.

British manufacturers make a charge of 2½% of the value for stencilling the importer's name on such goods and it is felt that the Commodity Prices Stabilization Corporation should not be called upon to subsidize the stencilling which merely serves as an advertisement for the importer.

* * * *

### Air Conditioning at St. Catharines Hospital

The St. Catharines General Hospital has recently completed the installation of an air conditioning unit for the three operating rooms, central supply room, and the nurses' work room. The air conditioning will be used the year round and an even temperature will be maintained at all times. Fresh air is brought in through screens and filters, washed, heated or cooled, forced into the rooms and passes out through the outside vents. This gives a constant supply of fresh clean air at proper temperature.

The surgeons and nurses are very pleased with the improvement in working conditions. They report that they now feel refreshed after working several hours in the Operating Room, where previously they finished feeling like "wet rags".

* * * *

### Perpetual Motion

The colored soldier had been peeling potatoes until his hands ached. Turning to a fellow K.P. he said: "What d'you suppose dat sergeant mean when he call us K.P.?"

"Ah dunno," replied his co-worker. "But from de look on his face, Ah thinks he meant 'Keep Peelin'."

*From heavy to delicate suturing...*

**Surgeons employing the Singer Surgical Stitching Instrument find that its versatility in simplifying difficult suturing techniques heralds it as one of the most important contributions to modern surgery. With the advent of the new smaller "Model A-11", the adaptability of the instrument has been extended to cover the entire range of suturing requirements. • The Singer suturing instrument, for instance, utilizes needles up to the *largest size*, or down to the *smallest size practicable* in surgical work... permits the use of *a wide range of suture material*—fed from a continuous spool supply... *speeds* the execution of old familiar stitches... and provides for *new* suturing procedures as well.**

**SINGER SURGICAL STITCHING INSTRUMENT**

**Unites needle, holder, suture supply and severing edge in one, self-contained instrument, sterilizable as a complete unit.**



**For the complete story, use the coupon for your copy of an illustrated booklet.**

Singer Sewing Machine Company
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Division, Canada — Dept. C.H. 95
Without obligation, send copy of illustrated brochure.

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**SINGER SEWING MACHINE COMPANY, *Surgical Stitching Instrument Division*, CANADA**
**254 Yonge Street, Toronto • 424 Portage Avenue, Winnipeg • 700 St. Catherine Street W., Montreal**

# Restrictions are Being Cancelled!

Almost every day now, in Canada and the United States, restrictions which have brought production to a standstill are being cancelled. Perhaps even before this advertisement reaches your desk favorable news on the resumption of deliveries on the famous Karr Springs will be announced.

In any case, you can now look forward to giving your patients and resident staff the real sleeping comfort that only Spring-Air affords.

Better plan your requirements in Spring-Air now!

TYPE 1.
Where low cost is the primary consideration, without losing sight of the patients' welfare, the roll edge Spring Air Economy Special with guaranteed Karr spring construction is particularly recommended.

Spring-Air

**Dependable Hospital Bedding**

**Inner Spring Mattresses**

**Felt Mattresses**

**Beds Pillows**

**Springs of All Types**

•

***Write us regarding your requirements***

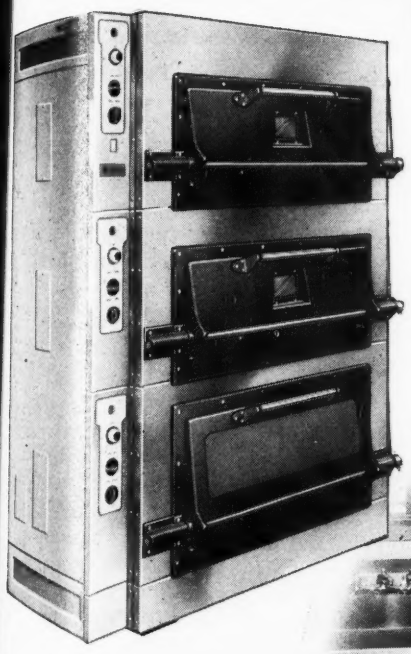
**THE CANADIAN FEATHER & MATTRESS CO. of OTTAWA, LTD.**
**692 Wellington St., Ottawa**

**SLEEPMASTER, LIMITED**
**41 Spruce St., Toronto**

**PARKHILL BEDDING LIMITED**
**Winnipeg**
**Regina, Saskatoon, Edmonton, Calgary**

**VANCOUVER BEDDING LIMITED**
**600 West Sixth Avenue, Vancouver**

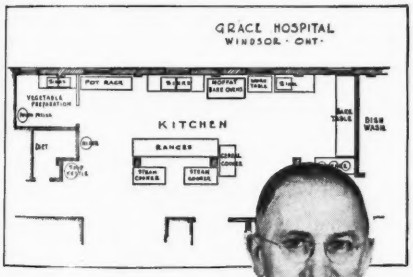
# Recent Installation of Moffat Electric Cooking Equipment *makes headline news*

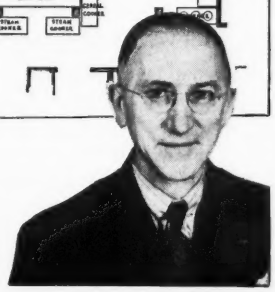


NEW GRACE HOSPITAL WING AT WINDSOR CHOSE MOFFAT ELECTRIC COOKING EQUIPMENT

Photos show actual Moffat installations at Grace Hospital Wing at Windsor, equipped with Moffats 3-Deck Bake Oven, capable of cooking sixty 9" pies or 81 standard loaves of bread. Also shown is a Moffat 6-slice toaster and domestic type Moffat Electric Range.

Reproduced below is the actual kitchen plan of Grace Hospital Wing.



J. P. Thomson, M.R.A.I.C., who prepared plan of recent new wing at Grace Hospital, Windsor.

## "Steady Performance and Economy of Operation"

*is why Architect Thomson of Windsor specifies*

## MOFFAT COOKING EQUIPMENT!

"I am really sold on Moffat products, having found them to be completely reliable, always giving continuous service with no let-downs. In institutions especially, such as the Grace Hospital, where a heavy strain is put on cooking equipment, the steady performance and economy of operation of Moffat Equipment has made it standard specification with me."

All Moffat Commercial Cooking Equipment is now available without special permit.

**MOFFAT** *Electric*
**COMMERCIAL COOKING EQUIPMENT**
*Canada's Most Complete Line*
MOFFATS LIMITED · WESTON, ONTARIO

ONE OF A SERIES OF THE FORCEFUL ADVERTISEMENTS APPEARING IN A WIDE LIST OF TRADE PUBLICATIONS

## Across The Desk

*(Continued from page 12)*

### Billiard Tables Needed at Malton

Officer patients at Malton's new 500-bed convalescent hospital which opened in late July could use a billiard table and a pool table to beguile the long and weary days of their convalescence. The Ontario Division of the Red Cross is supplying the furnishings for the officers' ante-room. If anyone has a billiard table or a pool table which they would like to contribute to this institution, they are asked to get in touch with Mr. Stafford Roberts, 62 Jarvis St., Toronto.

* * * *

### Trane Company Appointments

Mr. R. N. Trane, President, Trane Company of Canada Limited, recently announced the following executive appointments. Grant E. Cole has been made Executive Vice-President and General Manager; J. S. Roberts, Vice-President, Treasurer and Assistant Secretary; J. W. O'Neill, Vice-President in charge of production.

**Grant E. Cole**

Together since 1924 Messrs. Cole, Roberts and O'Neill, have guided the Canadian Company to a point where it holds a reputable position in the industrial and residential heating, cooling and air conditioning field today.

* * * *

### Birth of Linoleum in 1863

Linoleum, according to the Dominion Oilcloth & Linoleum Co., Limited, was born eighty-two years ago between the thumb and finger of an English inventor named Walton. Searching for a floor covering tough and resilient, yet able to take attractive colourings and not be costly, he absent-mindedly picked up a piece of the "skin" from an old paint can. As he was rolling this between his thumb and finger he suddenly realized that he had in his hand exactly what he was seeking!

It was tough, elastic, resilient, smooth in texture and in colour, impervious to moisture—and durable. Linoleum dates from that day. After eighty years of improvement, it is still essentially oxidized linseed oil mixed with resilient cork.

* * * *

Age lends the graces that are sure to please:
Folks want their doctors mouldy, like their cheese.

*O. W. Holmes.*

The Earl of Chesterfield said it
— and we believe him!

# "Whatever is worth doing at all is worth doing well"

That is why the reputation of Stafford's for quality products is only a spur to the relentless search for improvement carried on by our experts in the basic food material field. The acknowledged quality of the Stafford line is a tribute to the painstaking care and scientific pre-testing which goes into every product.

Stafford's are proud of the fact that they manufacture the most complete line of basic food products in Canada — they are prouder still of the fact that each of these is backed by a guarantee of purity and reliability that enables you to buy with complete confidence and satisfaction.


Stafford's
LABORATORY CONTROLLED
BASIC
FOOD
MATERIALS

- FOUNTAIN FRUITS
- TOPPINGS AND SYRUPS
- BEVERAGE SYRUPS
- FOUNTAIN FUDGES
- SUNDAE SAUCES
- FOUNTAIN FLAVOURS
- HOT CHOCOLATE POWDER
- MALTED MILK
- ICE CREAM BASES
- FRUITS FLAVOURS AND BAR COATING
- FRUIT JUICE CRYSTALS
- ORANGE CONCENTRATE
- JELLY POWDERS
- CUSTARD POWDERS
- DESSERT POWDERS
- PIE FILLERS
- CAKE MIXES
- FRUITHICK
- BAKER'S FLAVOURS
- MERINGUE POWDER
- GRAVYRICH
- BOULLEX
- BREADING
- ONION AND GARLIC POWDERS
- SOUP BASES
- DEHYDRATED VEGETABLES
- SPICES
- SEASONINGS

Price list available upon request

STAFFORD INDUSTRIES LIMITED - TORONTO

COAST-TO-COAST DISTRIBUTION

# How Soon?

Shown here are a few of the best known members of the famous Hobart line of Food Preparing Machines. They are typical of the products that will be available to you when Hobart facilities are entirely released from wartime duties.

During the war years we have been able, in a very limited way, to supply certain types of civilian installations. By the end of this year we'll be in a position to supply considerably more Hobart equipment as our facilities are being swung over gradually to full production for the civilian market.

There still is much to be done far afield, and supplies will continue to be limited for quite some time. As we "convert for peace" you may expect us to use the same energies, the same resources and the same all-out co-operation that were employed when Hobart converted for war.

**THE Hobart MANUFACTURING COMPANY LIMITED**

*The World's Largest Manufacturer of Food Preparing Machines*

**119 CHURCH STREET TORONTO, CANADA**

## Across The Desk

*(Continued from page 16)*

### More Milk from Fewer Cows

Despite the fact that the dairy farms of Canada lo the help of more than half of their young men durin the war years, Canadian dairy farmers responded to th appeal for greater production by increasing the output of milk by over two billion pounds and at the same tim by milking more cows.

* * * *

### Ted Moore Returns to J. & J.

"A. E. (Ted) Moore who is welcomed back by his associates at Johnson & Johnson Limited, and his many friends in Saskatchewan. Ted joined the armed forces in 1942 and served as a Staff Sergeant Armourer until his release a few weeks ago."

* * * *

### Major Tilston, V.C., with Sterling Products

Major Fred Tilston, V.C., who received a civic welcome at Halifax, Toronto and Windsor on his return to Canada a few weeks ago, is a Sales Manager for one of the companies controlled by Sterling Products, Limited, Windsor. He is at present at Christie Street Military Hospital, where he is being fitted with artificial legs.

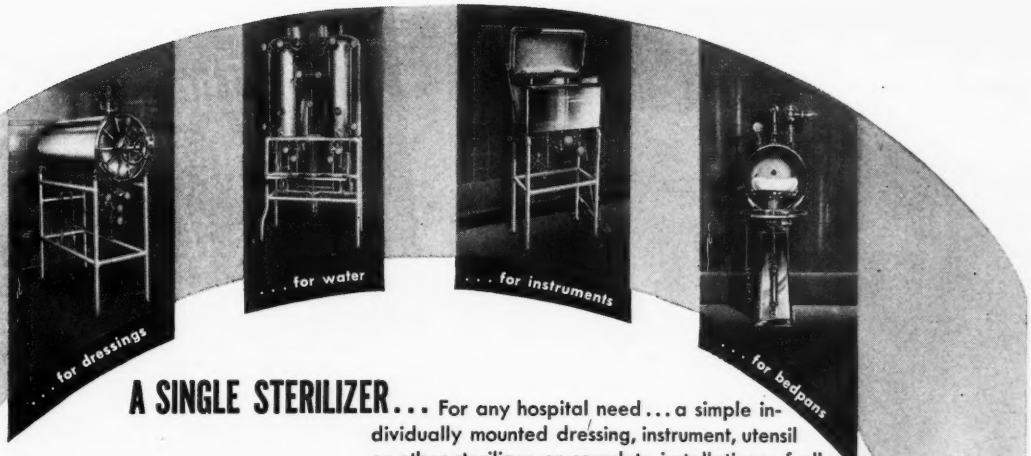
* * * *

### New Crane Booklets

Two new Crane booklets are designed to help administrators bring their hospital piping, and the men responsible for its maintenance, back to peacetime par.

For management: This gives you a practical working plan for checking and rehabilitating piping systems which have had to "stand the gaff" in the face of minimum maintenance, substitutes replacements and wartime schedules.

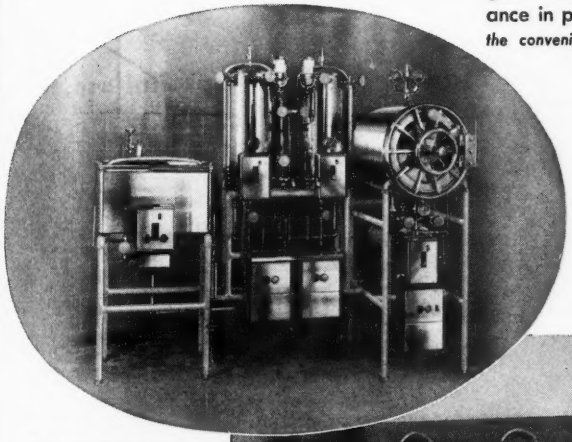
For your men: Gives basic piping facts in readily understandable form; primarily intended as a practical reference guide for industrial maintenance men, this "Piping Pointers" manual also provides educational data for juniors, apprentices, assistants and all those who must have, during their training periods, reliable information on proper piping practice.




## A SINGLE STERILIZER...

For any hospital need... a simple individually mounted dressing, instrument, utensil or other sterilizer, or complete installations of all sterilizing equipment . . . apparatus heated by steam, gas or electricity... Scanlan-Morris sterilizing equipment meets every hospital requirement. • Many years of experience in equipping hospitals and clinics, and the direct personal contact with superintendent, surgeon and architect, enable us to give valuable assistance and authentic guidance in proper planning for sterilizers. • *Send the convenient coupon below for complete information.*

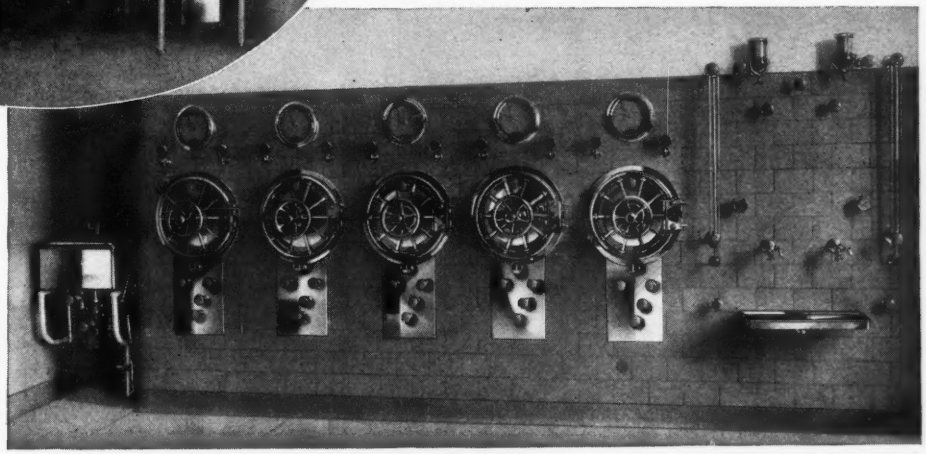
## A GROUP...



*Electrically heated autoclave, set of water sterilizers (hot and cold) and a combination instrument and utensil sterilizer.*

## OR COMPLETE HOSPITAL INSTALLATIONS

Shown below is a typical Scanlan-Morris equipped sterilizing room —at Charity Hospital, New Orleans, La., a 3000-bed hospital completely equipped with Scanlan-Morris sterilizing apparatus.



**SCANLAN-MORRIS DIVISION**
**THE OHIO CHEMICAL & MFG. CO.**

General Sales Office: 745 Hanna Bldg., Cleveland 15, Ohio
Represented internationally by Airco Export Corporation

MANUFACTURERS OF: **Sterilizing Apparatus • Operating Tables**
**Operay Surgical Lights • Scanlan Sutures**

The Ohio Chemical & Mfg. Co., 745 Hanna Bldg., Cleveland 15, Ohio
Send Sterilizer Catalog to:

Name _____

Address _____

City _____ State _____ CB

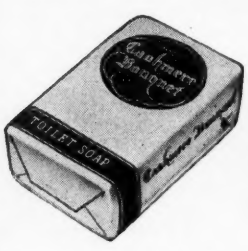
# Check These 3 Reasons Why Colgate's Floating is the Ideal Hospital Soap!


## Made specially for hospital use, it's unsurpassed for purity . . . for mildness . . . for economy!

The three major requirements of a soap for patient care are purity, mildness, and economy. Colgate's Floating Soap meets all three, *because in its development, hospital needs were given first consideration!*

In purity, Colgate's Floating meets the highest hospital standards. Nurses and patients agree that it is exceptionally mild and kind to the skin. And in cost, hospital superintendents find Colgate's Floating an agreeable surprise!

Let us quote you prices on the sizes and quantities you need. Ask your local C.P.P. representative for full information. Or if you prefer, write direct to Colgate-Palmolive-Peet Co., Ltd., Hospital Dept., Toronto, Canada. No obligation, of course!




For use in private pavilions, and particularly for women patients, we suggest Cashmere Bouquet. A fine, white, hard-milled soap, it is famous for its rich, creamy lather . . . its delicate, lingering perfume! Available in a variety of miniature sizes.


Palmolive is becoming increasingly popular among hospitals, both for staff use and for patient care. Canada's favorite toilet soap, it meets the highest hospital standards in purity. Palmolive, too, is available in miniature sizes.

**Colgate-Palmolive-Peet Co., Ltd.**

Hospital Department, Toronto 8, Canada

# *Peace and Rest*

## FOR THE DISTRAUGHT PATIENT

THE unrelenting distracting torment of pruritic skin lesions can readily upset the mental and emotional equilibrium of any patient, however stolid. Instant and complete relief of itching is the patient's urgent demand; eradication of the lesion becomes a matter of secondary interest. With Calmitol, the patient's desires are dependably satisfied. Itching is stopped virtually instantly, and for prolonged periods. Quickly the tenseness of the patient gives way to peace and rest, and relaxation is again possible. Calmitol has become the first thought in pruritus, regardless of cause or other indicated treatment.

*The Leeming Miles Co. Ltd.*

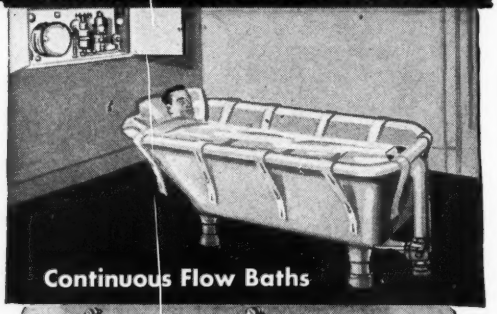
504 St. Lawrence Blvd., Montreal, Canada

The active ingredients of Calmitol are camphorated chloral, menthol and hyoscyamine oleate in an alcohol-chloroform-ether vehicle. Calmitol Ointment contains 10 per cent Calmitol in a lanolin-petrolatum base. Calmitol stops itching by direct action upon cutaneous receptor organs and nerve endings, preventing the further transmission of offending impulses. The ointment is bland and nonirritating, hence can be used on any skin or mucous membrane surface. The liquid should be applied only to unbroken skin areas.

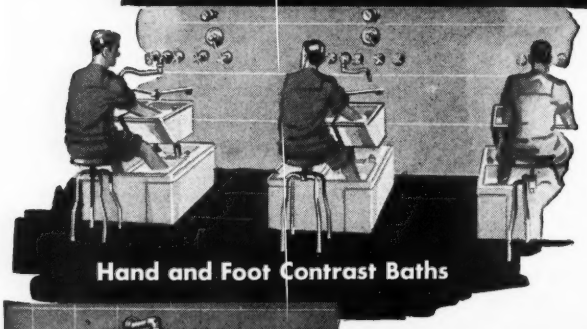
**CALMITOL**

**THE DEPENDABLE ANTI-PRURITIC**

Continuous Flow Arm and Leg Baths



Continuous Flow Baths



Hand and Foot Contrast Baths

# Healing War's Wounds

For maladies of war—both physical and mental—hydrotherapy is proving a valuable aid in promoting rapid recovery.

Arm and leg baths aid in advancing recovery in peripheral nerve injuries, indolent ulcers, adherent scars, osteomyelitis of terminal phalanges and fractures after the removal of the cast.

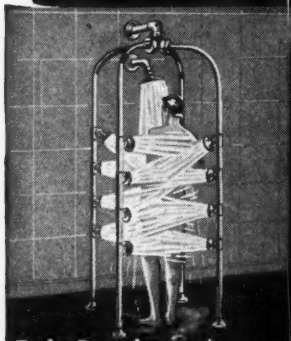
Continuous flow baths provide a gentle massage and are recommended by many authorities in the treatment of mental and nervous disorders.

Hand and foot contract baths are used by many hospitals and sanatoriums in treatment of circulatory diseases and other conditions where alternate heat and cold are indicated to stimulate circulation.

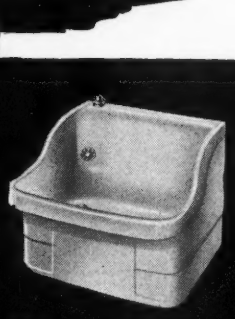
Hydrotherapeutic showers are of value in providing a rain douche or needle spray shower, supplying a stimulating massage in nerve cases, or a shock treatment in mental cases.

The complete Crane line of hospital plumbing includes every item necessary for the hydrotherapeutic department. Because of the value of hydrotherapeutic treatment in war casualties and in the promoting of civilian health, you may be considering installing such a department or expanding your present one. If so, consult your plumbing contractor or the nearest Crane Branch for complete information.

CRANE LIMITED: HEAD OFFICE:
1170 BEAVER HALL SQUARE, MONTREAL

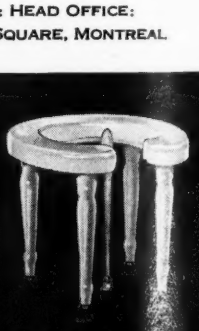


Rain Douche and Needle Spray Shower



Sitz Baths—using cold, neutral and hot water—offer a wide range of hydrotherapeutic applications.

Foot-Soak Baths are recommended for conditions requiring long immersion in hot or cold water or antiseptic solutions.



The Perineal Douche delivers solid stream or spray. It is of value in treatment of the pelvic organs.

**CRANE** VALVES • FITTINGS • PIPE
PLUMBING • HEATING • PUMPS

NATION-WIDE SERVICE THROUGH BRANCHES, WHOLESALERS and PLUMBING AND HEATING CONTRACTORS

Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, September, 1945 Vol. 22 No. 9

# New Basis of Health Insurance Proposed at Ottawa Conference

A NEW programme for health insurance and specific health grants was proposed by the Hon. Brooke Claxton, Federal Minister of Health, at the opening session of the Dominion-Provincial Conference at Ottawa on August 6th. At least, the plan modifies to a considerable degree the proposed measure considered by the Special Committee on Social Security during the past two years.

The major change is that the provinces may adopt health insurance features on the instalment plan, rather than be required, if they desire federal subsidy, to adopt a fairly complete plan as outlined in the old model provincial act. This modification will make it easier for a province to develop a plan proportionate to its facilities and resources, although it remains to be seen whether or not this leads to the omission of certain desirable features, so carefully safeguarded in the former proposal.

### Stages of Development

The initial procedure in the development of a plan of health care is to be the drafting of a health insurance programme by each province interested. For this purpose the federal government will grant $620,000 to finance the necessary staffs and studies in the provinces. Within 18 months provincial governments accepting this grant must submit a health insurance programme satisfactory to the Dominion cabinet. Then, within two years of the signing of a Dominion-provincial agreement, the *first stage* of health insurance must be in effect in the province.

*The Hon. Brooke Claxton, Minister of National Health and Welfare.*

*First Stage*

This "first stage" calls for the provision of **general practitioner service, hospital care and visiting nurse service.**

For this partial coverage the federal government will provide $70,000,000; the provinces are to contribute the remaining $45,000,000. Cost of this coverage is estimated at $10.20 per capita, the federal government paying $6.12. (See Table I.)

*Second Stage*

At the time of signing the agreement, a deadline will be set after which the "second stage" is to be in operation. This will provide other medical services such as con-

**sultant, specialist and surgical care, private duty nursing care, dental care, drugs, sera, surgical appliances and laboratory services.**

For the total coverage the federal government would contribute $150,000,000, or $12.96 per capita. The provinces would be asked to contribute an additional $100,000,000. Total cost is estimated at $250,000,000, or $21.60 per capita.

Each province would determine how its share would be raised. However, the Dominion will require that the province collect from each resident of 16 years of age or over an annual registration. Two dollars is suggested. This is the only mention of any contributory factor.

#### Assistance to Hospitals

In view of the obvious fact that the setting up of health insurance services will require "a considerable extension of hospital facilities throughout the country" the federal government has offered to furnish financial assistance in the erection of hospitals.

The federal government proposes to lend provincial governments and, through them, municipalities and other organizations, funds for necessary hospital expansion. These loans would be at interest rates equal to the cost of such loans to the Dominion, and would be repayable out of the health insurance grant, the tuberculosis grant, or the mental health grant as the case might be. Loans would be made only to provincial governments participating in the health insurance plan. Presumably the province in turn would lend the money to the hospitals interested. (See box insert.)

#### The Health Grants

In addition annual health grants amounting to $13,600,900 are proposed. These will likely be arranged without delay, irrespective of the adoption of the health insurance proposals. The following grants are suggested:

| | |
|---|---|
| General public health | $4,022,600 |
| Tuberculosis | $3,000,000 |
| Mental health | 3,987,000 |
| Venereal disease | 499,500 |
| Crippled children | 497,900 |
| Professional training of public health workers | 250,000 |
| Public Health research | 100,000 |
| Lowered pension age for blind to 21 years | 1,243,900 |
| Total | $13,600,900 |

"The National Health Programme also contemplates the construction of a National Laboratory as a postwar development project, the extension of health services to the Civil Service, the application of proper health and sanitation standards for the federal government buildings, the development of the National Fitness programme, the provision of consultative services for departments of the federal government, and a very great increase, wherever possible, in all fields of co-operation between the federal and provincial governments, so as to press forward the best possible health programme for the people of Canada."

* * * *

## First-Glance Comments

The federal proposals are quite generous and would seem to be very fair to the provinces.

This new proposal appears to overcome the somewhat controversial point as to whether the federal government had the right to set up a plan of national health insurance. However Ottawa still has the right to withhold support unless the provincial plans be satisfactory.

The new system should make it much easier for a province to develop a health insurance plan. It was very questionable in the minds of those best informed that the government could set up a complete plan, as of the first of a selected month, in the larger provinces at least.

**Table I**

**BASIS OF FEDERAL CONTRIBUTION FOR HEALTH INSURANCE**

**(dollars per capita)**

| Service Provided | Estimated Average Cost of Service* | % of Total Cost | Basic Dominion Grant (20% of total est.) | Maximum Additional Dominion Grant (50% of additional actual cost to maximum) |
|---|---|---|---|---|
| | $ | % | $ | $ |
| **First Stage** | | | | |
| General Practitioner Service | 6.00 | 28 | 1.20 | 2.40 |
| Hospital Care | 3.60 | 17 | 0.72 | 1.44 |
| Visiting Nursing Service | 0.60 | 3 | 0.12 | 0.24 |
| Total First Stage | 10.20 | 48 | 2.04 | 4.08 |
| **Later Stages** | | | | |
| Other medical services (including consultant, specialist and surgical) | 3.50 | 16 | 0.70 | 1.40 |
| Other nursing services (including private duty) | 1.15 | 5 | 0.23 | 0.46 |
| Dental care | 3.60 | 16 | 0.72 | 1.44 |
| Pharmaceutical (drugs, sera and surgical appliances) | 2.55 | 12 | 0.51 | 1.02 |
| Laboratory services (blood tests, x-rays, etc.) | 0.60 | 3 | 0.12 | 0.24 |
| | 21.60 | 100 | 4.32 | 8.64 |

*Estimated cost to be revised on basis of actual costs after three years.

## Assistance for Hospital Construction

*From "Proposals of the Government of Canada"*
*Ottawa Conference, August, 1945.*

(b) **Activities for which the provincial governments are responsible and which the Dominion is prepared to consider assisting provided specific agreements can be reached. . . .**

4. Assistance to promote particular national programmes. . .

*(ii) Assistance to promote rapid increase in hospital facilities required for inauguration of health insurance as outlined in the section on the National Health Programme.*

* * * *

(d) **Financial assistance in the Construction of Hospitals:**

*It is recognized that the provision of complete health insurance services would require a considerable extension in hospital facilities throughout the country. Much of this expansion would be required even for the first stage specified. It is also recognized that this expansion would be desirable quite aside from health insurance in order to provide the proper facilties for treatment and research.*

*To make a hospital extension programme less burdensome to the provincial governments and to local communities, it is proposed that the federal government should provide loans to the provincial governments entering health insurance agreements, and through provincial governments to municipalities and other organizations, for necessary expansion of hospital facilities, at a rate of interest equal to or only slightly above the cost of such loans to the Dominion, and that the interest and amortization would be payable out of the hospital care benefit under the Health Insurance Grant, or out of the Tuberculosis Grant or the Mental Health Grant, as the case may be.*

The new plan seems weakened, however, by the absence of the model provincial act. Without a rigid yardstick of appraisal, inadequate provincial plans are more apt to be approved and the all-important federal subsidy obtained. One desires assurance, for instance, that the indigents would be amply covered in any partial plan and not left on the doorsteps of the hospitals and the doctors. This, we understand, is the federal intention.

The recognition that adequate hospital facilities are a pre-requisite of any comprehensive health plan and that construction must be assisted from governmental funds is welcomed. It is improbable that in any province in the country the necessary accommodation could be provided to-day—or even several years hence—without substantial aid, federal or provincial.

Apparently loans at reasonable interest are to be made through the provincial government, the hospital in each case being required to deal with its own government. This may mean that the provinces will have to guarantee the loan and, in so doing, guard against unnecessary or over-optimistic construction.

The Federal Government would seem to be weakening on the point of personal contribution. First it was $26 per annum per individual, then $12 per annum and now the token payment only of $2 is suggested. This is not even called a contribution; it is an annual "registration" fee which, of course, could be readily discontinued. Of course the provinces could require a personal contribution, but the proposal mentions only what the provinces, not the beneficiaries, would pay. It will be a sorry day for the spirit of our people and for the economical operation of the plan if the federal and provincial governments carry practically the full cost with little or no direct personal contribution.

It is a matter of regret that the provision of adequate low-cost diagnostic facilities is not an early provision. Expert diagnosis requiring intricate laboratory and radiological procedures and highly-trained consultants is not available in many areas and is an expensive procedure where it is available. Earlier and more accurate diagnosis at a reasonable cost would be a godsend to thousands of people.

The three first items included—general practitioner service, hospitalization and visiting nurse service—will be popular, but we hope that the

*(Concluded on page 76)*

**Table II**

**COST TO THE FEDERAL GOVERNMENT OF INITIAL BENEFITS UNDER HEALTH INSURANCE**

FIRST STAGE

(In thousands of dollars)

| Province | General practitioner service | Hospital care | Visiting nursing service | Total |
|---|---|---|---|---|
| Prince Edward Island | 342 | 206 | 34 | 582 |
| Nova Scotia | 2,081 | 1,248 | 208 | 3,537 |
| New Brunswick | 1,646 | 988 | 165 | 2,799 |
| Quebec | 11,995 | 7,197 | 1,199 | 20,391 |
| Ontario | 13,636 | 8,181 | 1,363 | 23,180 |
| Manitoba | 2,627 | 1,576 | 263 | 4,466 |
| Saskatchewan | 3,256 | 1,935 | 323 | 5,514 |
| Alberta | 2,866 | 1,720 | 287 | 4,873 |
| British Columbia | 2,944 | 1,767 | 294 | 5,005 |
| Total cost to Federal Government | 41,393 | 24,818 | 4,136 | 70,347 |

*If Health Insurance comes*

# What Hospital Facilities Will be Needed?

HARVEY AGNEW, M.D.

THE Federal Government, at the recent Federal-Provincial Conference at Ottawa, proposed a gradual approach to nation-wide general health insurance, the first stage to be the provision of hospital, general practitioner and visiting nurse services. It is recognized that this undertaking will require "a considerable extension of hospital facilities throughout the country".

How much hospital expansion will be necessary? And what associated factors must be considered?

### Essential Features

Essential features dealing with hospitalization in any program of health insurance providing hospital care for the population as a whole were reviewed recently before the General Council of the Canadian Medical Association. In essence the features are as follows:

I. *Adequate hospital accommodation*

Active general hospitals,
Hospitals for the chronically ill,
Convalescent hospitals,
Special hospitals—
Tuberculosis, mental, communicable disease.

II. *Provision for financing the costs of construction*

This cannot be left to voluntary effort and the municipalities.
The Dominion and/or the provinces must bear a fair share.

III. *Adequately trained personnel*

New or greatly expanded hospitals will require greatly increased personnel. Many of these must be highly trained and, therefore, steps must be taken well in advance of the opening of these new buildings or wings to train the personnel required. The following highly trained personnel, among others, must be available.

Administrators
(a) professional background
(b) lay, or business training.
Nurse supervisors,
Nurse instructors,
General duty nurses,
Radiologists and pathologists,
Laboratory and x-ray technicians,
dietitians,
Physiotherapists,
Medical record librarians.

IV. *Adequate Payment for Services*

As wages rise and scientific knowledge advances, the cost of maintaining hospitals is steadily mounting. Hitherto, payments from public sources have seldom equalled the cost of providing care. If a large proportion, or perhaps all, of the patients come under a health plan, it will be essential that payments be adequate to keep the hospitals solvent and that payments be so determined that hospitals will be encouraged to expand and improve their facilities.

V. *Diagnostic services*

Most of the more intricate and technical diagnostic procedures are

*Amplified from a report on "Basic Requirements for the Improvement of Health Services" by the Committee on Economics, Canadian Medical Association.*

### Hospital Beds Needed in Canada

**These estimates are of the construction required to fully meet our needs, not the amount under construction. Also the figures for active beds are on the assumption that an adequate number of beds for chronic and (in larger communities) convalescent patients will be provided; otherwise the estimate of active beds should be increased.**

**The increased figures for a decade hence are on the assumption that a considerable degree of social legislation involving hospital care will be in force by that time.**

**Table I**

| | *Present No.* | *Total Present Need* | *Total needed 10 years hence* |
|---|---|---|---|
| Active ..... | 45,609 (public) | 55,000 | 65,000 |
| Chronic ..... | 2,632 | 13,500 | 16,000 |
| Convalescent .. | 900 | 2,200 | 2,500 |
| Tuberculosis .. | 12,060 | 19,560 | 19,560 |
| Mental ..... | 38,928† | 50,000 | 55,000 |
| Communicable Diseases .... | 1,437‡ | 3,000 | 3,000 |
| Totals .... | 101,566 | 143,260 | 161,060 |

†43,443 in residence Dec. 31, 1942.

‡There are only 15 isolation hospitals in the whole of Canada.

now done in the hospital. In the "second stage" of the Federal proposal, if not before, diagnostic services are to be provided. These services will be provided largely by doctors, working in hospitals and it is hoped that any "diagnostic centres" established will be in connection with hospitals. Therefore adequate laboratory and other diagnostic provisions should be made in the new construction.

VI. *Rural Areas*

The provision of hospital care for people in sparsely settled rural or isolated areas offers a difficult problem and should be given careful study. Special arrangements should be considered, such as small emergency and maternity outpost hospitals, travelling clinics similar to tuberculosis clinics, aerial ambulances and travelling consultants and administrative and clinical tie-up between a small rural hospital and one in a nearby centre. A visiting nurse service linked with the public health services, the doctors and the hospital is essential.

### Beds Required?

At the time of the National Health Survey, conducted by the Canadian Medical Procurement and Assignment Board with the assistance of the Canadian Hospital Council and other organizations, a serious shortage of accommodation throughout Canada was revealed. The picture has definitely deteriorated in the interval. At the present time the following summarizes the general situation:

i. *General (active) hospitals*
Definite shortage in all but a few rural centres; situation quite serious in most large cities with no margin whatsoever for peak demands.

ii. *Hospitals for the chronically ill*
Very short everywhere: most areas, including many fair-sized cities, have no accommodation worthy of the name, for chronic patients. These patients must either take up badly needed beds in general hospitals or try to find whatever care they can with relatives or strangers.

iii. *Convalescent hospitals*
Very few in Canada. Whole provinces are without proper convalescent beds. Adequately equipped and organized convalescent hospitals are in two cites only.

iv. *Tuberculosis Sanatoria*
Shortage of beds in nearly all provinces.

v. *Mental Hospitals and Institutions for the Feeble-minded*
Serious shortage everywhere.
*Reception hospitals*—badly needed in most large centres.
*Psychiatric annexes* to general hospitals needed in selected large hospitals.

### Estimate of Needs

It is not practicable to be slavish in following set formulae relating to the number of beds of various types required per thousand of population. Studies in various counties and provinces reveal a wide variation in the ratio that seems to be needed to meet requirements.

For instance, the number of active beds required per thousand of population depends upon several factors:
Industrialization of area,
Housing conditions,
Availability of domestic help,
Transportation in winter,
Proximity of large centre with good doctors and hospitals,
Proportion of people enrolled in voluntary hospital plan, industrial plan, or favorable hospital legislation (such as maternity benefits in Alberta),
Accommodation available in hospitals for chronic patients, convalescents or the senile.
Financial status of people,
Attitude of the public towards going to the hospital.

Some hospitals, (e.g. Alberta and British Columbia) have twice as many active beds as have others, yet are still short. Some cities have as high as 15 to 18 public beds per thousand of population and are badly in need of more beds. Moreover, under any system that would provide hospitalization without immediate cost to the patient, the requirement in every province would rise sharply. Therefore, the commonly quoted figures of 5 beds per thousand for a province and of 6 to 7 beds for a city must be taken *cum grano salis;* in fact, like most generalizations they are usually misleading when applied to a specific situation.

Estimates of present and future needs have been made in several provinces; in two instances the studies have been quite carefully done on a county or district basis. The Department of Hospital Service of the Canadian Medical Association has taken available data of a reliable nature—provincial studies, local surveys, etc.—and filling in gaps on a parallel basis has prepared the estimate of need given in Table I (p. 30). The estimate of tuberculosis beds needed was furnished by Dr. J. G. Wherrett of the Canadian Tuberculosis Association and that of mental requirements by the National Committee on Mental Hygiene.

### Costs of Construction

Most hospital consultants are very hesitant to make any specific estimate of the cost of construction or even of maintenance in the immediate future.

Construction costs are fluctuating at the present time with only a modest drop anticipated in the postwar years. The best informed opinion at the present time would suggest that the average cost of active hospital construction should be placed at about $5,000 per bed. It is quite likely that much construction will be done at lower figures, particularly if only a wing is being built or a small building of less durable construction. On the other hand

**Cost of New Construction Required**

**Table II**

| | *Immediate expenditure* | *Additional within 10 years* | *Total* |
|---|---|---|---|
| Active ..... | $ 46,955,000 | $ 50,000,000 | $ 96,955,000 |
| Other ..... | 129,212,000 | 31,200,000 | $160,412,000 |
| | $176,167,000 | $ 81,200,000 | |
| | | Grand total ..... | $257,367,000 |

**Summary of Operating Costs**

| | *If present needs are met* | *To meet needs 10 years hence* |
|---|---|---|
| Active hospitals | $ 52,195,000 | $ 61,685,000 |
| Chronic and Incurable patients | 8,869,000 | 10,512,000 |
| Convalescent hospitals | 1,927,200 | 2,190,000 |
| Add: | | |
| Tuberculosis Sanatoria | 23,203,050 | 23,203,050 |
| Mental Hospitals (prov.) | 28,387,500 | 31,116,250 |
| Communicable Disease Hospitals (municipal) | 1,368,750 | 1,368,750 |
| | $115,951,000 | $130,075,050 |

(These figures do not include the cost of hospitalizing war veterans under the D.V.A.).

standards of construction are constantly rising and some of our large-scale construction with extensive kitchens, boiler plants, residences, outpatient clinics, etc., may reach $8,000 to $10,000 a bed. A better method of calculation is on the cubic foot basis, formerly 55-65 cents—now reaching 80-85 cents.

The construction of hospitals for chronic or incurable patients, for tuberculosis patients and for mental patients should cost less, but, considering the services to be provided, it is estimated by competent architects that these would average $4,000 a bed. The modern, well-equipped convalescent hospital will probably cost as much.

"These figures seem high but several building authorities with recent experience have stated that, if anything, they are low; they feel that, under present conditions, the estimate of a 40 per cent advance on prewar prices should be accepted. Moreover, building costs, we are informed, are not likely to drop to any great extent during the next few years, execept that the quality of labour and of materials should improve."

On the above basis, the cost of new hospital construction required in Canada would be for (a) *present expenditure*—active hospitals $46,955,000; other, $129,212,000; total, $176,167,000; (b) *additional within 10 years*—active hospitals, $50,000,000; other, $31,200,000; total, $81,200,000. This would make a grand total at the end of ten years (if all needed hospitals were built—active, chronic, convalescent, tuberculosis, mental and isolation) of $257,367,00.

The report further states:

"This total would be spread over the next ten years; however, at the end of that period it is likely that further expansion, though at a reduced tempo, would be needed. In addition to a continued increase in use, heavy replacements would be necessary as many of our present buildings are fast becoming obsolete."

**Costs of Operation**

As for costs of operation, it is quite likely that the rapid rise of the past few years will be continued for several years before it levels off. Present labour unrest for higher wages and shorter hours has increased hospital budgets beyond all expectation and further demands may be anticipated. Much obsolete equipment will need replacing and depleted stores must be re-supplied, much out of current revenue.

Reported costs are now all obsolete before being published. The more careful studies made have indicated that many of the costs reported seldom include all factors and are usually below actual cost. The most recent and the most exhaustive study, that in Ontario reviewed elsewhere in this issue, reveals that the average cost for standard services in 111 public hospitals was $4.13 per patient day in 1943, and $4.42 in 1944. This year and next will be still higher. One city hospital of under 100 beds had a cost in 1943 of $6.25; another of 75 beds reported $5.21. Reports from other provinces indicate rising costs.

Presuming a conservative national average of $4.00 per patient-day for active hospitals and allowing for a 65 per cent average occupancy (which is the accepted average to meet peak demands) the annual cost of maintenance for 55,000 beds would be $52,195,000 and for 65,000 beds (10 years hence), $61,685,000. These figures may well be higher.

Estimating $2.00 for hospitals for chronics and incurables and a 90 per cent occupancy, the cost of operation for 13,500 beds would be $8,869,500 and for 16,000 beds ten years hence, $10,512.000. (This per diem estimate is probably too low if proper medical and nursing care be given.)

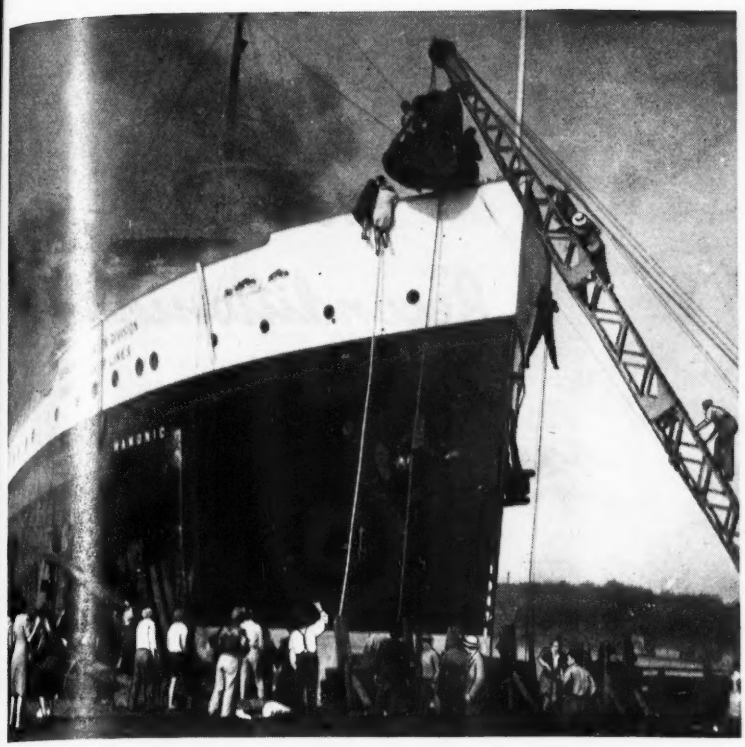
As for convalescent care, present costs vary from $2.00 to $3.25 depending upon the extent and quality of the rehabilitation care given. Presuming we are dealing with institutions properly equipped to provide physiotherapy, occupational therapy, etc., at an average cost of, say, $3.00 and counting on an average occupancy of 80 per cent, the annual operating cost for 2,200 beds would be $1,927,200, and for 2,500 beds, $2,190,000.

**Annual Outlay**

For practical considerations, the total cost of construction could be amortized over the ten year period covered. This would work out at $25,736,700 per annum. Likewise, the costs of operation of the hospitals estimated as necessary today and the possible costs of the larger number of hospitals a decade hence could be averaged on an annual basis:

| | |
|---|---|
| Amortized construction costs over 10 years | $ 25,736,700 |
| Averaged operating costs over 10 years.. | $123,013,025 |
| **Total Annual Cost** | **$148,749,725** |

This staggering cost represents what would be the annual cost if adequate hospitals to meet our needs be provided. Costs of veterans' hospitals would be additional. Also, in estimating total cost, the extra costs for private accommodation beyond "standard" service should be considered. Practically speaking, it may be a long time before we achieve anything like reasonably adequate accommodation, but in these days when theorists talk glibly of utopian low cost health benefits the public should know what only one facet of this service will cost if anything like satisfactory service be given.



# The "S.S. Hamonic" Fire

By JOHN T. BARNES,

Chairman, The Sarnia General Hospital, Sarnia, Ont.

A GREAT general of the U.S. army once said "War is Hell" but, because of it, we in Sarnia were prepared to care for all casualties resulting from the burning of the luxury liner "S.S. Hamonic" as she lay anchored to the wharf of the C.N.R. freight sheds at Point Edward, Ontario.

Sarnia and district were declared a vulnerable area in 1940, with the result that its citizens were constantly on the alert for an alarm which might cause havoc to the whole territory due to the nature of our industries. Through the influence of the C.D.C. (Civilian Defense Committee) and its medical section, many auxiliary organizations were formed, including a St. John Nursing Division, the Imperial Oil Nursing Division, the Red Cross and many First Aid teams. Members of these organizations all received practical experience in the Sarnia General Hospital after completing their basic course and were thus prepared and well qualified to meet any emergency.

That emergency happened on Tuesday, July 17th, 1945 at 8.30 a.m. To have 150 or 200 casualties, mostly American tourists, drop in on you unexpectedly, especially in a hospital already overcrowded, is an experience not easily forgotten. Greater co-operation was never displayed. Engineers, janitors, orderlies and maintenance men helped to strip the nurses' residence of most of its beds, and to bring extra beds out of storage. These were set up in the corridors on the first and second floors. While some patients had to rest two in a bed, the seemingly impossible was accomplished under the supervision of Miss R. M. Beamish, general superintendent. At no time were the 136 regular patients at 90 per cent of the hospital's capacity neglected — including two babies who were born during the excitement.

Most nurses on duty did a double shift, and all nurses of the local Registered Nurses' Association responded as a unit. All major operations were cancelled for the day and the operating theatre was held open for casualty patients only. Seven available doctors rose to the occasion to handle the many cases. Fractures were set, plasma was administered, burns treated and many operations performed. When the hospital's regular supply of blood plasma was depleted, more was brought in by plane from Toronto.

The temporary 40-bed hospital at Polymer (Synthetic Rubber Company) built during the construction period of this large Dominion-owned plant was leased over a year and a half ago by the Sarnia General Hospital Commission and held in readiness against such an emergency with a prayer that it would never be needed.

Apart from shock the greater number of casualties were burn cases caused by patients sliding down rope fire-escapes. This created second degree burns on the hands and legs, while other passengers received first and second degree burns on the face and body from the fire and heat. The more serious cases suffered internal injuries and fractures from jumping or falling from the boat onto the dock or shore, a distance of some 35 or 40 feet.

By 11.30 a.m. all patients had

*(Concluded on page 80)*

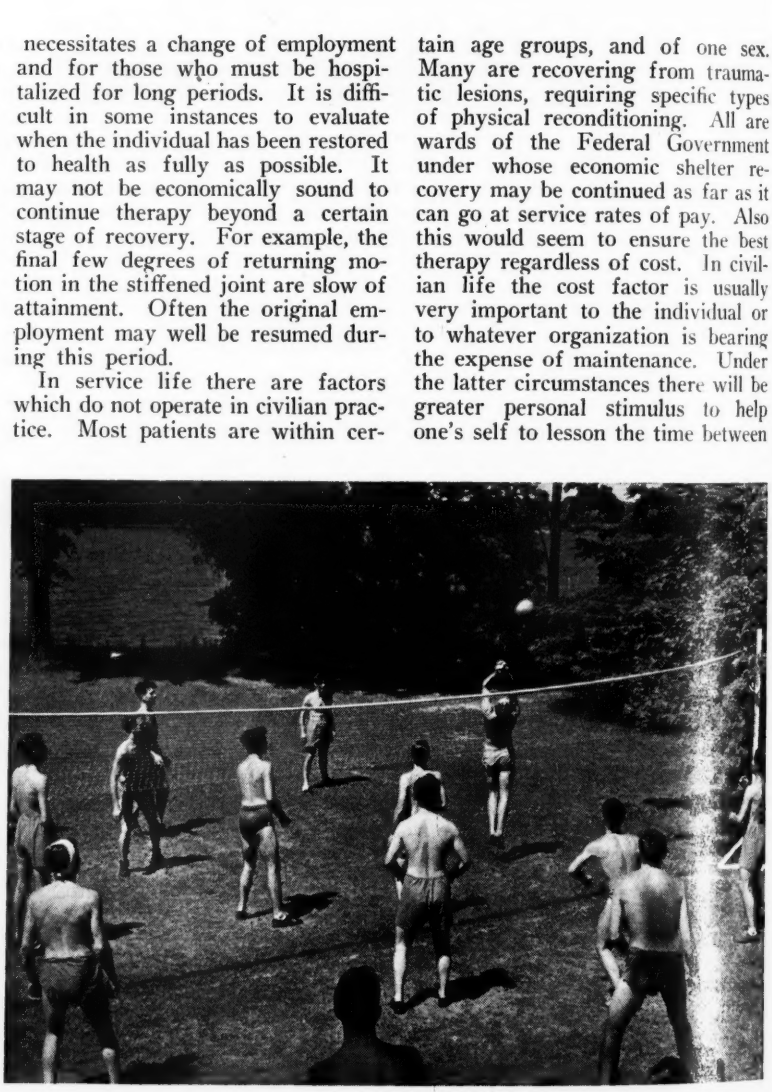
# Medical Reconditioning

By WING COMMANDER A. W. FARMER,
Consultant in Surgery, R.C.A.F.

SPORADICALLY for many decades articles have been written on medical and social rehabilitation, but the volume of literature on the subject appearing during the past five years tells the story of the increased interest resulting from the treatment of this war's casualties. The Tomlinson Report on the rehabilitation and resettlement of disabled persons noted the trend to better convalescent care in the United Kingdom and made specific recommendations for future development. In the United States of America the Baruch Committee on Physical Medicine has given much aid financially and otherwise toward the development of medical education in this problem. In Canada, too, preceding this war serious thinking and planning was being done by isolated groups. An outstanding example was the Workmen's Compensation Board of Ontario as a part of whose organization a department of rehabilitation was established many years ago.

Since the onset of this war, planned programmes of medical reconditioning have been placed in operation with varying degrees of success by the three armed services and the Department of Veterans Affairs. On casual examination, these programmes differ much. The main objectives of all programmes is the same—namely, to restore the individual to health and re-employment as quickly as possible. There may be secondary objectives, particularly for those patients who are going to have a permanent disability which necessitates a change of employment and for those who must be hospitalized for long periods. It is difficult in some instances to evaluate when the individual has been restored to health as fully as possible. It may not be economically sound to continue therapy beyond a certain stage of recovery. For example, the final few degrees of returning motion in the stiffened joint are slow of attainment. Often the original employment may well be resumed during this period.

In service life there are factors which do not operate in civilian practice. Most patients are within certain age groups, and of one sex. Many are recovering from traumatic lesions, requiring specific types of physical reconditioning. All are wards of the Federal Government under whose economic shelter recovery may be continued as far as it can go at service rates of pay. Also this would seem to ensure the best therapy regardless of cost. In civilian life the cost factor is usually very important to the individual or to whatever organization is bearing the expense of maintenance. Under the latter circumstances there will be greater personal stimulus to help one's self to lesson the time between




definitive care and return to work.

The R.C.A.F. have a medical reconditioning programme which was planned for operation in active treatment and convalescent hospitals. The difficulties encountered during its development were surmounted by various means and several valuable lessons were learned. While not considered ideal, it has largely accomplished its purpose. It will briefly be described and commented upon. Those who are planning programmes for civilian hospitals or other organizations may find some of the remarks helpful.

In the R.C.A.F. a planned programme is used only in active treatment hospitals of 70 beds or more and in the convalescent hospitals. Of the latter there are thirteen spaced from the Atlantic to the Pacific Oceans. Two of these are on R.C.A.F stations, and eleven use properties acquired through an organization known as Wartime Convalescent Homes War Charity Fund Incorporated. This latter organization also provided other help and without their aid the whole project would not have been possible. The programme is in all cases under the direction of medical officers and for purposes of description is roughly subdivided into:

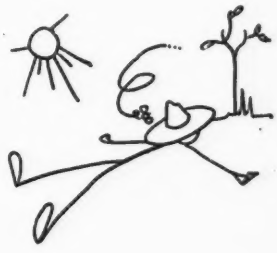
(1) Rest
(2) Occupational therapy
  (a) remedial
  (b) diversional
(3) Physical therapy
  (a) Heat, massage, electrical stimulation, hydrotherapy, mechanotherapy, etc.
  (b) Physical exercise—specific (remedial), general.
(4) Vocational Retraining
  (a) For return to duty

  (b) For return to civilian employment.

In the active treatment hospitals, the patients are mainly confined to bed or in an early ambulatory stage and are distinguished by red and white tags. In the convalescent hospitals patients are all ambulatory and are divided into three groups marked by white, blue, and green tags, the latter representing the condition nearest to full recovery and capability for full physical activity. All parts of the programme as outlined for the individual patient in convalescent hospitals are compulsory. A reassessment of the condition of each patient by the medical officer is made weekly for purposes of upgrading and recording the progress of recovery. The programme is explained to the patients as soon after hospital admission as their condition will allow. They are given a pamphlet to peruse which describes the programme of activities between their definite treatment and their return to work and which is designed to obtain their whole hearted cooperation. Moving pictures are also used in this education.

All those who take part in the programme must do so enthusiastically, firmly believing in its value. This includes the medical officers, the nurses, physiotherapists, masseurs, physical training instructors, occupational therapists, educational officers, hospital aids, etc., as well as the patients.

In the R.C.A.F. it has been found advisable to concentrate certain types of cases and thus some of the convalescent institutions have become specialty hospitals for orthopaedic, plastic, general medical and surgical, and neuropsychiatric cases. This has

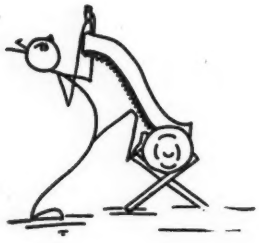


been allowed for easier administration (planning of programme, etc.), more equitable distribution of facilities (e.g. all the orthopaedic units have excellent swimming pools), and easier training and distribution of all the personnel coming into contact with the patients.

*Occupational therapy*—Due to the scarcity of individuals trained particularly for hospital occupational therapy, those with skills in crafts and hobby work are used. In the R.C.A.F. programme this therapy has been largely of a diversional nature, only occasionally an occupation being specifically prescribed to help remedy an existing disability. This is for the same reason as noted previously. This is counterbalanced by placing more emphasis on remedial physical exercise in the treatment of a specific disability. Because this therapy is largely diversional many of the machines used both in the active treatment and convalescent hospital are power driven. The patients almost invariably show great interest

in work with wood, plastics and leather, and the fabricated goods are of professional quality. The materials used are charged to the patient. Stock is replenished with the money received. There is a continual small loss by this method which is made up by a yearly grant from service funds. The fabricated goods become the patients' personal property.

There are many other forms of



occupational therapy which do not need to be enumerated in detail here. All of the convalescent hospitals have photographic rooms and libraries. Many have greenhouses for all year round gardening and all have extensive properties requiring considerable up-keep.

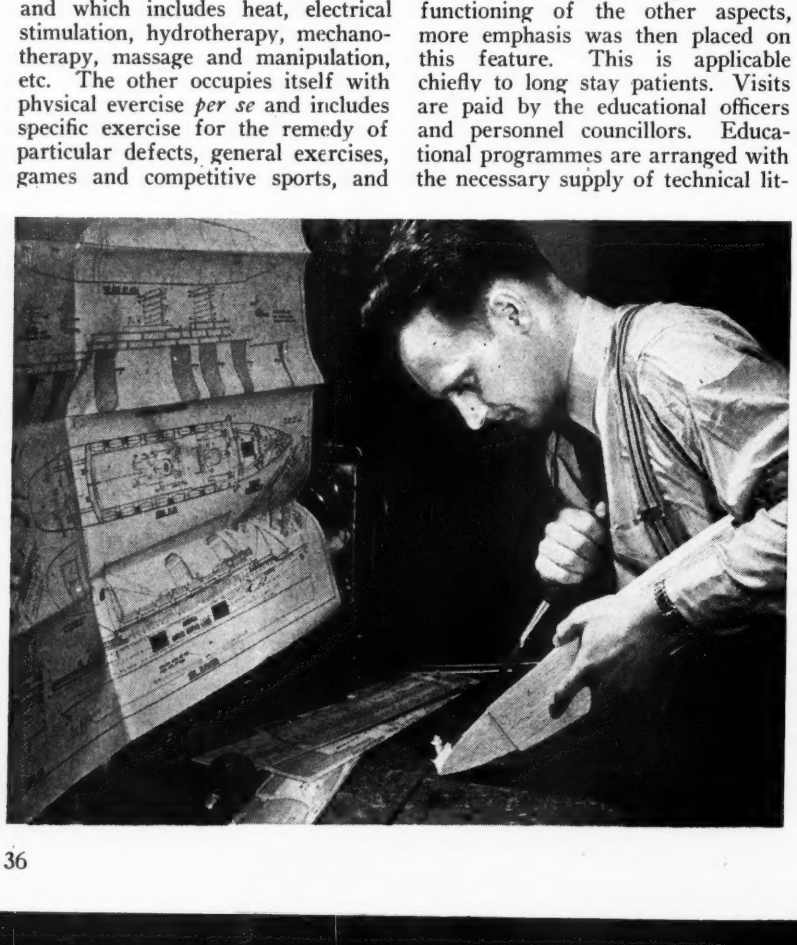
*Physical Therapy*—This has been roughly divided in the R.C.A.F. programme into two parts: one of these employs a number of mechanical aids and which includes heat, electrical stimulation, hydrotherapy, mechanotherapy, massage and manipulation, etc. The other occupies itself with physical exercise *per se* and includes specific exercise for the remedy of particular defects, general exercises, games and competitive sports, and occupations designed to cause considerable physical activity (bicycling, cross country hikes, etc.). Both parts are closely integrated in their management. Physiotherapists who are graduates of recognized schools of physiotherapy and masseurs who are under their direct supervision take charge of the first part. The second part is managed by physical training instructors who have had special teaching on patient problems. There is allowed one physical training instructor to approximately fifty patients in active treatment hospitals and one to fifteen patients in convalescent hospitals.

The facilities necessary for this part of the programme are considerable. Besides the usual mechanical apparatus for heat, electrical stimulation, etc., there is needed sports equipment and considerable inside and outside space. The only limiting factor in the R.C.A.F. programme has been the provision of the inside space for gymnasia in convalescent hospitals. This difficulty has been surmounted in a variety of ways, chiefly by the provision of adequate transport and the use of the closest Y.M.C.A. etc., facilities.

*Vocational Retraining*—Little effort was given to this part of the programme in its initial stages. With the satisfactory development and functioning of the other aspects, more emphasis was then placed on this feature. This is applicable chiefly to long stay patients. Visits are paid by the educational officers and personnel councillors. Educational programmes are arranged with the necessary supply of technical literature. Groups are escorted on trips through industry to familiarize themselves with working conditions which they may be required to meet. Guest speakers on a variety of entertaining and educational subjects are heard. Those patients who, on account of permanent partial disabilities, are not likely to return to duty, are encouraged to give thought to their future in civilian life and to outline an educational programme which will be helpful in obtaining suitable employment. Many departments of government have a responsibility in this matter and the R.C.A.F. programme does not attempt to take rehabilitation to its finality in individuals who, on account of physical incapacity, must leave the service.

The greatest difficulty encountered in establishing a comprehensive medical reconditioning programme was in obtaining personnel who were either trained or interested in this type of work. The lack of interest on the part of medical officers has been chiefly due to lack of knowledge concerning the subject, there being little concerning it in the average medical school, and the great bulk of the literature concerning it being of fairly recent vintage.

The validation of such comprehensive programmes from an economic point of view is difficult. Much clinical and statistical investigation is needed on the subject. However, there is no doubt in the minds of those who have been closely associated with the R.C.A.F. medical reconditioning programme that it has and is paying the nation large dividends by returning many difficult cases quickly to useful employment, healthy in mind and body.



***Photographs, courtesy R.C.A.F. Illustrations by Miss Marjory Riddell.***

# Valuable Analysis of Operating Costs Released by Ontario Committee

WHAT is probably the most exhaustive study of hospital operating costs ever undertaken in this country has been released by the Joint Study Committee of the Ontario Hospital Association and the provincial Department of Health. This is a study of 1943 costs and was the outcome of a similar spot analysis of the costs of some twenty-eight hospitals made in the previous year.

Although full financial and other returns have been made to the government for many years, much new data was required for this study. Not only were more departmentalized details required but it was found essential to unify interpretations of items across the province. A corps of accountants loaned by various hospitals met for some days to unify their own interpretations, following which they were made available to the other hospitals in their areas.

One hundred and eleven hospitals participated. These represent over 98 per cent of the total bed capacity of all public general hospitals in the province (exclusive of Red Cross outpost hospitals.) Only five hospitals were not able to supply the extensive data required.

Chairman of the Joint Committee was the Hon. Dr. R. P. Vivian, with Norman H. Saunders as Chairman of the Sub-committee on Hospital Costs which worked out this particular study. In addition to the Committee members, a clerical staff of

**More than half a million computations were required in this study. For the average hospital 4,500 completed calculations were necessary. Some 600 workdays were taken up.**

ten has been engaged on this lengthy study. The equivalent of 600 work days were required to complete the computations which totalled more than half a million in all. Actually some 4,500 completed calculations were necessary to analyze the per diem cost of operation in the average hospital.

The costs for 1943 of a number of the departments of each hospital and other major items are given for each of the 111 hospitals. The bases upon which these costs were calculated were carefully worked out to provide a uniform basis in each hospital. Factors included or omitted are set forth in the text of the report.

The over all average cost for *standard** services, based on the total patient days and total costs for all hospitals, was as follows:

| | |
|---|---|
| Nursing Care | $1.310 |
| Intern Service | .041 |
| Dietary Service | .661 |
| Laundry Service | .187 |
| Housing | .333 |
| Miscellaneous | .692 |
| Operating Rooms | .403 |
| Delivery Rooms | .143 |
| Laboratory | .154 |
| Physiotherapy | .013 |

**Standard services include routine ward care (basic for all types of accommodation), ordinary nursing care, intern service, dietary service, laundry, housing, etc. Certain items such as meals for private duty nurses, telephone and additional items, including depreciation, for private and semi-private patients are not included. Outpatient costs are excluded.*

**Table I**

**Average Departmental Costs in Hospitals of Varying Size**

**Nursing care covers bedside care but not nursing service in operating and delivery rooms and elsewhere; dietary service refers to the overall cost; laundry service does not include laundry for staff—this is pro-rated to the various departments; miscellaneous includes administration, dispensary, sterile supplies, ward aides, ward maids and porters.**

| Item | I 501 beds and over | II 301-500 beds | III 201-300 beds | IV 101-200 beds | V 51-100 beds | VI 26-50 beds | VII 1-25 beds |
|---|---|---|---|---|---|---|---|
| Nursing Care | 1.280 | 1.353 | 1.487 | 1.290 | 1.334 | 1.283 | 1.253 |
| Intern Service | .067 | .103 | .024 | .014 | .017 | ..... | ..... |
| Dietary Service | .664 | .681 | .619 | .640 | .704 | .669 | .604 |
| Laundry Service | .183 | .191 | .190 | .183 | .186 | .213 | .184 |
| Housing | .421 | .265 | .344 | .275 | .340 | .243 | .286 |
| Miscellaneous | .888 | .627 | .743 | .617 | .513 | .512 | .408 |
| Total Routine Care | 3.503 | 3.220 | 3.407 | 3.019 | 3.094 | 2.920 | 2.735 |
| Operating and Emergency Rooms | .381 | .348 | .445 | .438 | .464 | .348 | .334 |
| Delivery Rooms | .094 | .115 | .167 | .187 | .197 | .136 | .143 |
| Laboratory | .183 | .233 | .180 | .152 | .090 | .052 | .010 |
| Physiotherapy | .020 | .015 | .018 | .009 | .005 | .003 | ..... |
| Occup. Therapy | .004 | .011 | ..... | ..... | ..... | ..... | ..... |
| Medical Records | .048 | .072 | .051 | .054 | .038 | .012 | .010 |
| Radiology | .147 | .135 | .123 | .159 | .105 | .076 | .039 |
| Radio-Therapy | .026 | .013 | .001 | .003 | .008 | ..... | ..... |

**Table II**

**Average Cost for Infants Care**

| Groups | Nursing: Graduate | Nursing: School | Nursing: Total | Laundry | Other | Total |
|---|---|---|---|---|---|---|
| I | $.486 | .247 | .733 | .185 | .451 | 1.369 |
| II | .472 | .268 | .740 | .157 | .395 | 1.292 |
| III | .269 | .335 | .604 | .195 | .246 | 1.045 |
| IV | .241 | .296 | .537 | .186 | .284 | 1.007 |
| V | .431 | .299 | .730 | .178 | .197 | 1.105 |
| VI | .631 | .024 | .655 | .201 | .251 | 1.107 |
| VII | .395 | .253 | .648 | .184 | .306 | 1.138 |

| | |
|---|---|
| Occupational Therapy | .003 |
| Medical Records | .047 |
| Radiology | .134 |
| Radiotherapy | .012 |
| | $4.133 |

Each hospital submitted also the comparable costs for the first six months of 1944. These figures indicated a rise during this subsequent six months of 6.92 per cent, or an additional $0.286 to the over-all average per capita cost. This would bring the average cost for the first half of 1944 to $4.419 for standard service. For 1945 a further increase could be anticipated.

The daily per capita cost varied considerably. For study purposes hospitals were divided into seven size groups:

*Group I—501 beds and over*

| | |
|---|---|
| Average | $4.406 |
| Highest | 4.695 |
| Lowest | 3.795 |

*Group II—301 to 500 beds*

| | |
|---|---|
| Average | $4.162 |
| Highest | 4.794 |
| Lowest | 3.528 |

*Group III—201 to 300 beds*

| | |
|---|---|
| Average | $4.392 |
| Highest | 5.280 |
| Lowest | 3.676 |

*Group IV—101 to 200 beds*

| | |
|---|---|
| Average | $4.021 |
| Highest | 5.607 |
| Lowest | 2.905 |

*Group V—51 to 100 beds*

| | |
|---|---|
| Average | $4.001 |
| Highest | 6.251 |
| Lowest | 2.334 |

*Group VI—26 to 50 beds*

| | |
|---|---|
| Average | $3.547 |
| Highest | 5.219 |
| Lowest | 2.120 |

*Group VII—1 to 25 beds*

| | |
|---|---|
| Average | $3.277 |
| Highest | 6.589 |
| Lowest | 2.280 |

Table I gives a summary of average departmental costs in the seven size groups.

### Private and Semi-Private

The additional daily per capita cost of services provided to private and semi-private in-patients was calculated. This amount would be additional to that calculated for "standard" services. These figures were not averaged but may be summarized as follows:

| | *High* | *Low* |
|---|---|---|
| I. 501 beds and over | $1.422 | $ .573 |
| II. 301-500 beds.. | .643 | .428 |
| III. 201-300 beds.. | .864 | .440 |
| IV. 101-200 beds .. | 1.184 | .351 |
| V. 51-100 beds .. | 1.513 | .295 |
| VI. 26-50 beds .... | 1.571 | .39 |
| VII. 1-25 beds ..... | 1.111 | .28 |

Items considered in the above figures include private duty nurse, meals, patients' meals, laundry, housing, depreciation on building and equipment, and telephone and switchboard.

### Nursery

The average cost per infant day for nursery care was $1.138, subject to increases since 1943 comparable to that for other figures given above. For the different size groups the average total was:

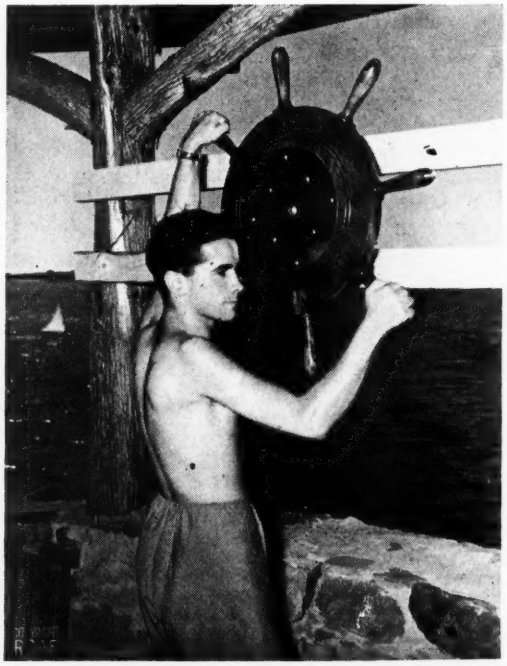
| | |
|---|---|
| Group I | $1.369 |
| Group II | 1.292 |
| Group III | 1.045 |
| Group IV | 1.007 |
| Group V | 1.105 |
| Group VI | 1.107 |
| Group VII | 1.138 |

The items are summarized in Table II.

### Outpatient and Emergency

The costs of maintaining *outpatient departments* indicates a wide variation in the cost per visit. Selecting a number of the hospitals with the largest number of visits, the costs are as follows:

*(Concluded on page 76)*



***Convalescent airmen regain muscle co-ordination through a series of scientifically-graded exercises.***


*Medicinal Baths*

*Copernicus*


*Hygeia*

# *Medical Philately*

**Part III**

This is the third of a series of reproductions of medical stamps from the collection of Miss Edna Poole, Librarian of the Toronto Academy of Medicine. Reproductions of other stamps in this collection appeared in the July and August issues.

Medical research has made so many noteworthy contributions during this War that it would not be at all surprising if several new medical stamps were to appear in the early future.

Another fine collection of medical stamps has been brought together by Mr. John H. Olsen, managing director of the Richmond Memorial Hospital, Dreyfus Foundation, Staten Island, N.Y.


*Hendrik Ling founded the Swedish system of gymnastics for therapeutic purposes.*


*Charles Darwin, whose "The Origin of Species" exerted a profound influence on contemporary scientific thought.*

*Vladen Djordjevic, who founded the Serbian Medical Association and the Serbian Red Cross.*

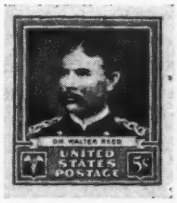

*Crawford Long, the first physician to use ether as an anaesthetic.*

*William Gorgas stamped out yellow fever in Cuba and Panama by screening patients and destroying mosquitoes.*


*Carl von Linnaeus, Swedish botanist and physician, who developed a classification of plants, animals and minerals.*

*Sun Yat Sen, the "Father of New China" was a licensed physician, receiving his license in 1892.*


*Sir Francis Bacon's "New Atlantis" gave great impetus to the formation of the Royal Society.*




*Walter Reed, American army surgeon, proved the cause and transmission of yellow fever by mosquitoes.*

*The "midnight snack", beloved of all nurses, is often difficult in a boarding house.*

# A Nurses' Home *or* Anybody's Home?

**By ELIZABETH K. McCANN, Reg.N., B.A., B.Sc.,**
**Vancouver, B.C.**

SIX administrators, all directors of nursing in large, well-run hospitals in widely separated areas in Canada and the United States, paused for a moment one day recently and considered. A hospital superintendent 1500 miles away had stirred their thoughts with a revolutionary question.

*Do student nurses need a residence connected with the hospital or can they, like University students, live apart from the institution? What is your opinion and why?*

That in essence was the purport of his telegram. One would anticipate, in reply, at least six widely varied answers based upon the practice and experience of those institutions. But the replies *endorsed unanimously* the need for a residence connected with the hospital. In fact, so in accord were their feelings that were it not for dates, postal marks and geography one would feel inclined to suspect collaboration.

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*Miss McCann is Senior Instructor at the Vancouver General Hospital Training School for Nurses.*

In fairness to their broadmindedness it must be said that a slight case was built up for "living out". It was suggested that students could more closely parallel their own home living quarters, and would feel happier, more independent and enjoy greater personal freedom. This is a factor especially for the married student whose home and husband are nearby. Greater opportunities may be possible in some boarding houses for personal entertainment. It was felt also that students living out would develop a "concept of cost", a sense of values and an adjustment toward economic security through a sense of responsibility. It was suggested that, if overcrowding was the problem, the probationers possibly could live out in their preliminary term until the time when ward work and studies must be co-ordinated (usually in six to eight weeks).

Senior students who have become well adjusted to nursing work and hours of study might live out. It was noted at one school, however, that when this privilege was offered to students, not one had accepted. All preferred to remain within "the home".

What then does that long-established, seldom-questioned "Nurses' Home" offer? Why is it needed for students? What are the returns to the hospital?

### Why a Nurses' Home?

The answer divides itself into two aspects—the practical and the aesthetic. Under the *practical* aspect we consider: (a) Cost, (b) Health and (c) Transportation.

(a) *Cost:* The cost of maintaining students in homes or boarding houses throughout the community is not covered simply by granting a "board and room" allowance to the students concerned. The necessity of providing dressing rooms, locker space and resting facilities involves considerable expenditure of money. The budgetary implications involve an estimate of student services to determine adequate compensation. In many hospital districts rooms in homes nearby would be unsuitable at the low rate of rent at which a hospital residence room could be obtained. Providing transportation or granting a travelling allowance and even providing escort service for night staff would likely be required

if satisfactory consideration is to be given to the student.

Meals too would be a problem unless the distance between hospital and nurses' rooms were negligible. Some provision for meals for night staff especially would involve an allowance for board away from the hospital.

(b) *Health:* The influence of separate residences upon the health of the students was a problem recognized and dwelt upon by each of these directors. The average age of first year student nurses, around nineteen years, is a time when good supervision is both needed and appreciated. Guidance in living independently, discipline for healthy living, protection from indiscretion and ignorance, can all be handled easily in a well-run "Nurses' Home". Good meals, carefully prepared and adequately supervised by dietitians, are assured. Adequate heat, plenty of hot water and *consistently* good living conditions can be assured in a nurses's residence; and the breakdowns in health—always the responsibility of the hospital—are more easily prevented and controlled. The tendency feared by our correspondents was that the student would attempt efforts beyond her capacity if permitted to carry on independently of the hospital. Too much social life, too little regular rest, inadequate or irregular diet, too much home responsibility (especially if tempted to keep house while taking the course) would not only undermine the student's own health but, through her fatigue and consequent inefficiency, undermine also the quality of service rendered to the patients under her care. As one principal put it, "fatigue of student nurses is more far-reaching than fatigue of other students since it is *dangerous* to patients".

*Recreational activities form a valuable part of the student nurses' training.*

Health problems cannot be passed over without mention of the unfortunate necessity for night shifts and broken hours along with what is sometimes a very heavy class programme. Rest periods under these circumstances suffer serious interference, since most individuals prefer their own rooms to rest areas provided by the hospital.

One writer stated very frankly that supervision is essential since nineteen-year-olds constitute the age group with a very high incidence of tuberculosis.

Recreation, an important factor in the maintenance of health, will be dealt with under aesthetic considerations.

(c) *Transportation:* Transportation difficulties are a major problem. Overcrowding of cars, unsatisfactory, undependable service, limited public and prohibitive private facilities, seem in themselves a very strong argument against outside rooms. The administrative problems associated with transportation seem unending. For instance, the necessity for having nurses on call and available *at once* as needed, especially in operating rooms; the need for odd hour shifts necessitating travelling at irregular hours; the difficulty in paralleling the training of two students so that those living together could have the same experience at the same time; the uncertainty, even, of day staff being consistently punctual; the interference and waste of off-duty study and recreational time due to the need of travelling away from the hospital (counting actual travel time plus the time for changing in and out of uniform); these are just some of the problems mentioned in this connection. Such a recital seems adequate proof of the desirability of having students live in residence.

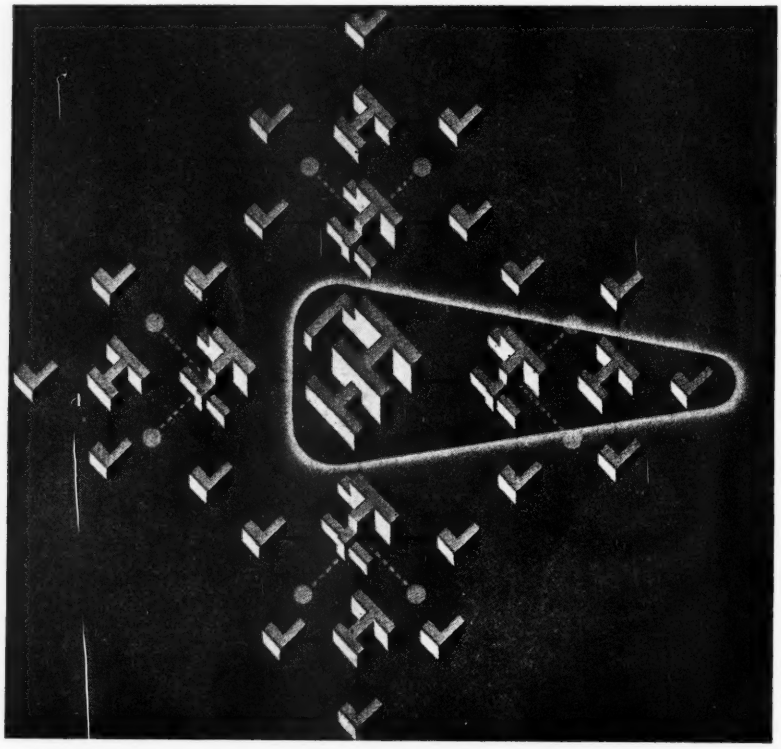

*A well-stocked library adds to the enjoyment of off-duty hours.*

### The Aesthetic Aspect

Finally we come to the aesthetic aspect. This may seem inconsequential in a dollars-and-cents way of speaking, but in the minds of these astute individuals it weighs the balance very heavily towards students living in residence.

It is difficult to measure or price that intangible sense of *esprit de*

*(Concluded on page 84)*



# Co-ordination of Hospital Service

## *As proposed by the U.S. Public Health Service*

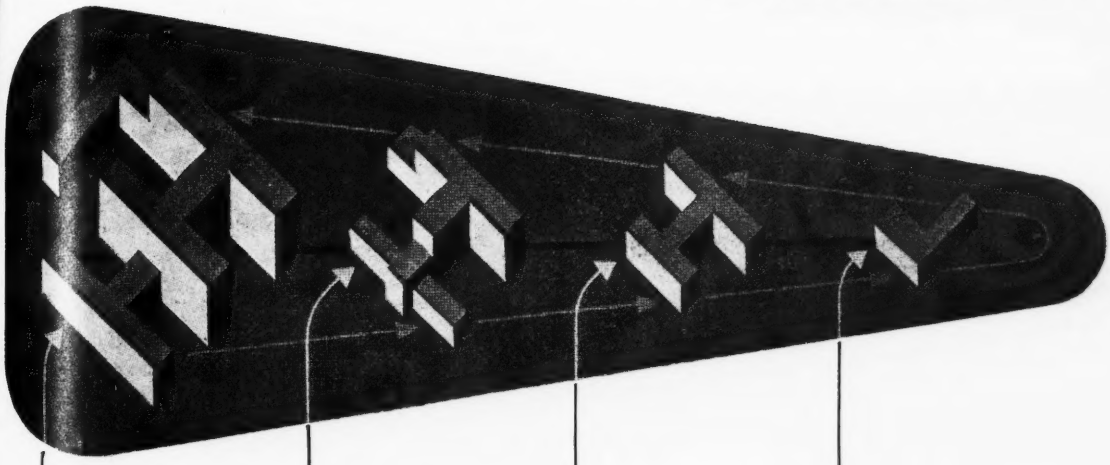
THESE diagrams illustrate the co-ordinated hospital plan suggested by Surgeon-General Thomas Parran, U.S.P.H.S. The three major aspects of medical care—preventive, diagnostic and therapeutic—would be provided through a network of hospitals and health centres. Units would range from the large "base" or "teaching" hospital out to the outpost emergency hospital and rural health centre. Here the chief activities would be of a preventive and diagnostic nature with only emergency care. Non-urgent cases would be referred centrally to the next unit. It is proposed that there would be constant interchange between hospitals of information, training of personnel and consultation services.

Says Dr. Parran, "The present-day doctor is trained to work with modern tools—hospitals, clinics and diagnostic aids. Unless hospitals and public health services organize to bring these advantages to rural areas, good health care for all is an unattainable goal . . . It is to be hoped that state planning commissions, in drawing up their long-range health and hospital programmes, will keep in mind the advantages of a co-ordinated programme, that well-established hospitals will grasp the opportunity to broaden their field of service through assistance to smaller institutions; and that small hospitals to be built will safeguard their standards by seeking association with larger institutions."

As a basis for evolving better hospital coverage the American Hospital Association has launched on a huge survey of existing hospital facilities through a special Commission on Hospital Care, directed by Dr. A. C. Bachmeyer and financed by the W. K. Kellogg Foundation, the Commonwealth Fund and the National Foundation for Infantile Paralysis. Extensive state support is being given and individual state surveys on the master pattern are being encouraged. This analysis of economic, population, geographic and other factors will be of tremendous value in planning postwar construction and development.

In Great Britain the hospital survey of Greater London by Drs. Gray and Topping points out that development of hospital services up to the present has been competitive and independent rather than co-operative. They found that although hospitals in London, Middlesex and Surrey showed much progress, local authority hospital services had yet a long way to go. The planning proposals made for the area outside the

**Detail from opposite page to illustrate function of each type of hospital**



### Base Hospital

*Teaching Research Consultation*

CANCER CLINIC
PSYCHIATRIC SERVICE
HEART CLINIC
MAJOR SURGERY
INTERNAL MEDICINE
OBSTETRICS
PEDIATRICS
ORTHOPEDIC SURGERY
COMMUNICABLE DISEASES
- Tbc., V.D., etc.

TEACHING
- Nurses
- Interns
- Residents
- Post Graduates

LABORATORY
- X-ray
- Pathology
- Bacteriology
- Chemical

PHYSIOTHERAPY
DENTISTRY
EYE, EAR, NOSE AND THROAT
DIETETICS

### District Hospital

MAJOR SURGERY
OBSTETRICS
INTERNAL MEDICINE
COMMUNICABLE DISEASES
- Tuberculosis
- Venereal Diseases
- Other

PEDIATRICS
EYE, EAR, NOSE AND THROAT
DENTISTRY
PHYSIOTHERAPY
LABORATORY
- X-ray
- Pathology
- Bacteriology
- Chemical

TEACHING
- Nurses
- Interns
- Dietetics

### Rural Hospital and Health Centre

INTERNAL MEDICINE
OBSTETRICS
EYE, EAR, NOSE AND THROAT
DENTISTRY
MINOR AND UNCOMPLICATED SURGERY
LABORATORY
- X-ray
- Bacteriology

ADMINISTRATIVE PUBLIC HEALTH OFFICES
- Health Officer
- Sanitarian
- Public Health Nurses
- Public Health Clinics
- Maternal and Child Health
- Tuberculosis
- Venereal Disease
- Public Health Education

### Rural Health Centre

OBSTETRICS EMERGENCY, MEDICAL AND SURGERY
LABORATORY
- X-ray
- Bacteriology

DENTISTRY
PRIVATE OFFICE OR OFFICES FOR PRIVATE PHYSICIANS
ADMINISTRATIVE PUBLIC HEALTH OFFICES
- Health Officer
- Sanitarian
- Public Health Nurses
- Public Health Clinics
- Maternal and Child Health
- Tuberculosis
- Venereal Disease
- Public Health Education

County of London recommended three types of hospitals—(a) district hospitals for all but exceptional cases; (b) special hospitals for specialized procedures; and (c) local or cottage hospitals in rural areas. These local hospitals would be linked with district hospitals.

Here in Canada some tie-up between rural hospitals has long been urged, particularly for administrative advice and assistance and for staff consultation. In its presentation to the Special Committee on Social Security, the Canadian Medical Association stated "if rural and urban hospitals could be so linked that patients could be quickly transferred when necessary to institutions with more elaborate equipment, the net result should be a reduction of mortality, more rapid convalescence and a definite saving of both skilled personnel and special equipment".

However, for the present this is not widely practicable because of the fee-for-service basis of payment for medical services. If under the proposed health insurance plans the capitation basis of payment be tried out in some areas, the transfer of certain patients to better equipped hospitals would be facilitated.

# Obiter Dicta

## *Central Civilian Blood Service*

NOW that the war is over there will be increased interest in the possibility that the great wartime blood donor service built up by the Canadian Red Cross Society may be converted into a nationwide peacetime plan to provide blood for use in civilian hospitals (see *The Canadian Hospital*, October, 1944, page 46). The sudden cessation of the Japanese war many months before it had been considered likely that such an ending would be achieved has closed down wartime collecting of blood before a definite decision respecting a possible peacetime arrangement could be effected.

Actually the problem of planning and organizing a blood donor service for civilian use requires extensive study and the Central Blood Donor Committee of the Canadian Red Cross has given serious thought to the many issues involved. This is as it should be, for the project is too far-reaching and involved to be lightly undertaken. Fortunately the services of Dr. Stewart Stanbury, formerly of Hamilton and now on leave from the British Ministry of Health, and a pathologist with wide experience in this field, have been obtained to survey the Canadian situation and make recommendations respecting technical details and organization.

For instance, it will be necessary to determine the form, or forms, in which the blood or blood products would be distributed. The service will be of most value in the smaller hospitals unable to develop their own blood banks, and such considerations as storage and ease of preparation and administration must be borne in mind. What type of container should be utilized? Will there be a danger of unnecessary use of blood if generous quantities be available? What charges should be permitted? Although the blood products may be supplied free, hospitals will still be under expense for the refrigeration and the administration of the blood. Much thought would need to be given respecting the optimum size of the unit and the best type of organization for collecting the blood.

The discovery of the Rh factor has complicated the technical and legal aspects of transfusion work. The Rh factor is now known to be responsible for many serious reactions and occasional fatalities. True, we do not hear of many reactions now but we may hear of more if there is a possibility that the responsibility may be shared with an outside organization. Blood grouping is relatively simple; the determination of the Rh factor, on the other hand, is much more difficult. Not only will there be the difficulty of getting specific serum but, to be accurate, checks must be made at varying temperatures and at considerable dilutions. We understand that all of the Rh determinations done in England in connection with the extensive transfusion service sponsored by the Government are done in three laboratories only. Know-

ing of this factor, there is now some legal responsibility on any person doing a non-urgent transfusion to check on this detail, particularly in the case of women. As these checks can only be done in a thoroughly competent laboratory, this is a complication here because of our formidable distances. However, much progress is being made and it is hoped that a satisfactory national plan can be evolved in the early future.

## *The Public Must Pay*

LAST month the hospitals in Toronto raised their rates fifty cents a day. This was found to be necessary to meet the increased costs of operation due to the further salary increases paid to certain groups of their employees. Public ward rates to paying patients have been raised from $3.00 to $3.50 per diem. Semi-private and private rates, with some variations in certain types, have been raised by the same amount. As an illustration of the added cost, this last increase adds another $225,000 to the wage bill at the Toronto General Hospital. Unfortunately only a portion of the patients are paying patients and the municipal and provincial payments for non-pay patients, although recently raised, are still far short of the actual cost of public ward care. Higher provincial and municipal payments will be needed to meet these additional costs.

With more unionization of employees elsewhere, more demands of this nature may be anticipated. The inevitable result must be higher charges to patients. Hospitals have no dividends to whittle down and there is no likelihood that other than minor economies here and there could be effected in operating methods unless we are prepared to lower efficiency or reduce comforts to the sick. Members of the public or of the press who criticize hospital management for keeping down operating costs should realize that hospital authorities have no personal bias in this matter; they are concerned with keeping the necessary charges to Mr. John Doe down to the point where the thrifty patient, trying to pay his own way, does not develop a coronary or become a mental patient worrying over the financial drain on his usually none-too-ample life savings. Fortunately for many thousands, the Blue Cross Plans will absorb the hospital costs.

There is another side to this subject. The public, now paying higher hospital charges than ever before, (the increase being mainly for wages) has a right to demand maximum efficiency from those receiving these wages. Most hospitals have on their payrolls ex-patients and others who would have great difficulty obtaining or holding permanent positions in the exacting and high-tension life of present-day industry. Some of these employees have been glad to have a steady job offering some consideration for their cardiac condition, their diabetes or other physical limitation. Is it realized that the public may now have the right to demand that only highly-trained, physically-able employees be utilized in order to obtain maximum efficiency for the money spent? If hospitals are to be put upon the same basis as industry, then hospitals—and their patients—have a right to demand the same exacting type of service from their employees.

## *Less Latin and Better Custard*

GIRLS in high school who aspire to become nurses should not be required to hold a middle school standing in Latin, has stated the director of education in a large eastern city in a report to the Board of Education. "It would seem", he states, "that the time might more profitably be spent in concocting a custard than in conjugating Latin verbs." As supporting evidence the doctor quotes an analysis of 664 medical prescriptions which revealed 37.5 per cent were in Latin, 51.3 per cent in English and 11.1 per cent in a mixture of Latin and English; that 44 Latin words were employed, 6 Latin phrases and 16 abbreviated directions in Latin. Of these words and phrases, 19 words and four phrases would not have been encountered in her school career. "Thus she would have spent three years in the study of Latin in order to acquire a knowledge of 25 Latin words and two Latin phrases."

Coming from such an eminent pedagogic authority as Dr. C. C. Goldring, this is a strong indictment of Latin as an essential subject. Lovers of the classics will protest, and with much logic, that Latin is more than utilitarian—that it is excellent mental training and discipline and, like Greek, opens up a great avenue of noble and exact expression. Unfortunately the vast majority of students of high school Latin never reach those heights where the reading of Latin becomes a joy unto the soul. In this day of scientific achievement many believe that mental discipline and accuracy can be achieved with more pleasure and future profit—to most students—by the study of physics, botany and chemistry. No one would deny the value of Latin as a high school subject, but the trouble is that its study usually necessitates the elimination of some other subject of probably greater value.

There has long been an impression that the student desiring to become a doctor or a nurse must know Latin. This revealing analysis of 664 prescriptions, however, would cast doubt on this assumption. Books on pharmacology and on materia medica (note Latin retention) list a page or two of the various Latin phrases used in prescription writing. Almost all of these are new anyway to the student of high school Latin. Adequate preparation for any of the Latin normally encountered in either medicine or nursing, including the recognition of unfamiliar English words, could be made by reverting to the old practice of teaching Latin and Greek roots in high school and then following this, as is now done, by a short intensive training in special phrases during the medical or nursing course. A rudimentary knowledge of declension would be desirable. It is of interest that in some medical schools the curriculum is being broadened to include more cultural subjects, particularly English literature and modern history, but there seems to be little inclination to increase the study of the classics.

# Helpful Suggestions from a Nova Scotia Administrator

**By REV. MOTHER IGNATIUS, C.M.S.,**
**Superintendent-General, Bethany, Antigonish, Nova Scotia**

HOSPITALS that depend on graduate nurses find it exceedingly difficult to maintain any stability in their nursing staffs. Much more personnel work is involved than when nurses were less transient. Only a small measure of relief is obtained by employing ward aids. One cause of this personnel problem is the minimum seven-days' notice which both the professional and non-professional workers in our hospitals feel that they can give before they leave their place of employment. This often creates a very great problem for the hospital administrator. If the care of the sick were a service in competition with any other service or industry, the decrease in efficiency due to shortages and rapid turnover of personnel might be tolerated. But under the circumstances, something should be done to remedy the situation. Might it be possible for our hospitals to insist that thirty days' notice be given? Or could we arrange for a legal contract between the hospital and worker that would safeguard the rights of both? . . .

In nursing circles, some discussion has taken place about the proposals from Toronto and from a few centres in the United States that we have two types of nurses, one with two years' training and one with four years' training. Some who have given thought to the proposals fear both these products; the first because she may not know enough about the reasons involved in the adequate care of the patient; and the second because she is to be trained in specialties and, not having much experience in direct care of the patient, will not be capable of directing the two-year nurse in good bedside nursing which is so important. This trend is one that should be watched and studied by our Maritime Hospitals. . . .

Most hospitals are over-crowded and, except where staff and accommodation have been expanded correspondingly, the results are not very desirable. The only large building programme which has gone ahead in our province is that of the Victoria General Hospital, Halifax, financed by the Provincial Government. Many of our local hospitals need additional room, but they are fearful of building on account of finances. In most cases the high cost of operating during the war period more than balanced the increased income from service by the hospitals, and the improved ability to pay on the part of most patients. Last year, following a resolution passed at our Annual Meeting, the Federal Government was petitioned for money for building purposes at a low rate of interest. This request was rejected. The matter should be taken up again at this Convention and we should solicit the interest of every hospital Association across Canada. If we could only get enough public support, I feel our petition might be favourably received. Our Governments are spending money on projects which are less important than the health of our people. Of the Government money that has been distributed for health, very little has provided effective means of improving hospital service—I refer particularly to the many military hospitals, especially erected during the war and which will now be of little use. Some of them are already closed. . . .

Another problem related to the financial aspect of our building programmes is technical advice. When a hospital is to be expanded or built, there should be available the services of an expert consultant. The best hospital architect will make mistakes in laying out floor plans, in the choice of materials, and in the thousand and one decisions that must be made in hospital planning. Evidence in our present hospitals prove it. Could we have in Canada a hospital consultant, perhaps working in conjunction with the Canadian Hospital Council, whose services would be paid for, at least in part, by the Association across Canada, and in part by each hospital making use of him? . . .

The Blue Cross Plan has been found to be a great help to the hospitals of the Maritimes, and particularly to the people it serves. We certainly owe a debt of gratitude to the Chairman and Executive Director. Miss Wilson has done a marvelous piece of work and she deserves the support and assistance of all those who are engaged in the hospital field. While the people support the Plan, its smooth operation for their benefit depends largely upon the hospitals and the medical men who are associated with the hospitals. The Plan has brought service to thousands of patients who otherwise could never have afforded it. It has paid hospital bills that otherwise probably never would have been paid. The hospitals and the doctors owe it to the public and to the administrators of the Plan to be strictly just. Any disposition on the part of the hospitals to expect more of the Plan than they would reasonably expect of a patient would soon create distrust and prevent an expansion of its benefits to the public and ultimately to the hospitals. The question of uniform rates, per diem costs and reasonable charges for all services has another practical aspect when considered in relation to the Blue Cross Plan. The doctors too should be fair. They should not keep their patients in hospital longer than is necessary, because when they do they create a great difficulty for the hospital and for the Plan.

A matter which should be seriously considered, particularly by our Nova Scotia hospitals, is the exposure of nurses, especially undergraduates, to infection by tuberculosis

*(Concluded on page 84)*

*From a report to the meeting of the Maritime Conference of the Catholic Hospital Association at Charlottetown in June.*

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# With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

*Dear Mr. Editor:*

For some time it has been in my mind that one of these letters ought to deal with the position of the medical profession in relation to hospitals under present conditions. My hesitation has been largely due to the fact that the subject is a delicate one. I am stimulated, however, to tackle it by a booklet which has just been published with the title, "Should the Voluntary Hospitals Continue?" It is the work of Mr. A. H. Leaney, who for twenty-seven years was House Governor of one of the big Birmingham voluntary hospitals. His travels have taken him across the Atlantic and in this country he is well-known as a fresh and stimulating thinker.

## *Position of Medical Staff in the Hospital*

Dealing with the constitution of the governing body of the voluntary hospital Mr. Leaney points out that it does not reflect the change in the source of income from charitable gifts to contributions from potential patients through contributory schemes. Then he continues in words which deserve quotation:

"The representation of the medical staff, as a rule generous, raises consideration. It has always been the practice in this country that government, especially with voting power, should not be vested in those who may profit by decisions made, yet the power of the medical staff in management grows at a time when an increasing part of their income depends, directly and indirectly, upon their connection with the hospital, and when the principle of payment of the visiting medical staff is being generally conceded.

"However much in theory the composition of the board be reasonably balanced as between lay and medical members, in practice it is often found that the medical staff has virtual control of the institution, and that their advice is not confined to professional and technical matters. Their representation on the board is justified insofar as it represents self-government in medical matters; but it cannot be justified unless the same privilege is given to other staffs whose services to-day are often as essential to the welfare of the patient as those of the doctor."

In this last proposal Mr. Leaney probably goes further than many of his colleagues would be prepared to follow him, and to many committees the idea might even seem to be revolutionary.

The position of the medical staff generally forms a separate section of the booklet. After paying a warm tribute to their work Mr. Leaney suggests that most of the changes required in the management of the hospital depend upon a modification of the privileges which have accrued to the consultant. Advance in medical knowledge and practice "with their mystic rites" have enhanced his personal position, and the consultant, with a presumed power over the most obscure and serious ailments, has been treated as a superman. But he can no longer conduct his work as such for he is now one of a team.

"The modern hospital", continued Mr. Leaney "has developed into a great machine with about thirty major departments; and if it is to be run well, smoothly and without waste every department must work in relation to others and to a timetable.

"Good catering is impossible if the doctor is at liberty to commence his rounds as meals are being served. Unless the times of his visits can be relied upon, the off-duty times of nurses and others cannot be pre-arranged; patients may be kept waiting in great anxiety in the anaesthetic room or in the outpatient department. Unexpected variation in the day of attendance may mean postponement of operation after the patient has been prepared physically and mentally, or a difficult journey from the country may have been unnecessary and may have to be repeated. Perhaps most disturbing of all is the postponement of a ward round or operating session from a weekday to Sunday, for the organization is based on the assumption that only really urgent duties will be done on that day, and the result is chaotic.

"It has come about that the one whose attendance might, in former times, be left to his own discretion without detriment to the working of the institution, must now be the most reliable and the most subject to discipline if the machine is to work with efficiency."

So it is that the medical staff must be ready to sacrifice some loss of freedom to come and go at discretion, if they are to make a satisfactory contribution to the work of the hospital. The proposed solution is that, to avoid an abrupt change from present practice, "the wisest course would appear to be that all future appointments should be made conditional upon regular hours of duty and that involves salaried service". The means to meet the cost, according to Mr. Leaney's proposal, would be provided through some system of State grants dependent upon local voluntary support.

This summarizes Mr. Leaney's line of thought upon one aspect of his subject and provides the main points of the position of the medical staff. It also supplies an example of the interest of the whole booklet, which is one of the few contributions made by a layman to the spate of matter based upon the proposals for the organization of national hospital service.

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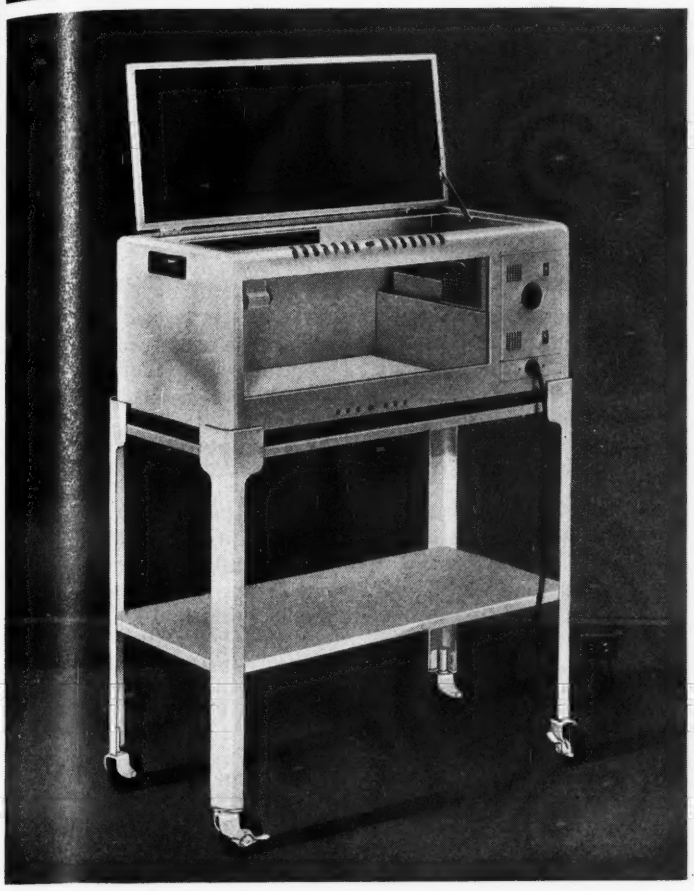

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## Certain Service Hospitals Available for Purchase

A number of the hospitals operated by the Armed Services and scattered throughout the country may be available for purchase as soon as no longer required. At a recent meeting of the Wartime Hospitalization Committee it was announced that the cessation of hostilities will make unnecessary the use of a number of these hospitals, and that there will be an opportunity for their conversion to civilian use, either as hospitals or in some other capacity.

It is quite possible that some of these hospitals, buildings and equipment, could be used by the local community either for active treatment or for the care of chronic or convalescent patients. Owing to the location of quite a few of these hospitals, their use as a hospital for patients suffering from chronic diseases would be highly desirable. At the present time there is a tremendous need for hospitals for chronic diseases in nearly all communities. In some instances a service hospital might be so located that it could be used as a convalescent unit in connection with one or all of the local general hospitals.

The Canadian Hospital Council has written to the various member hospital associations, suggesting that it might be possible to make a study in each province of the possibilities for using these hospitals, and that such studies might be made in conjunction with the provincial Department of Health.

All those interested in hospital development are requested to give some thought to this possible course of action. Quite a number of communities now without hospitals are considering the establishment of local institutions, either under voluntary or municipal direction. Some of the hospitals that should be available shortly might be admirably suited for such purposes. Any group or municipality interested should write directly to the service concerned—navy, army or air force. It would be well also to send a copy of any application to the Canadian Hospital Council. Although some of these hospitals may not be available for several weeks or months, application should be made without delay, as their utilization for other purposes may be requested. In any case the service concerned would want to dismantle the building when it is no longer required.

Voluntary hospitals wishing to take over buildings or equipment or both should file application also with the local municipality. Federal services, provinces and municipalities have priority rights, and public hospital requests will be recognized if routed through the municipalities.

## Employment of Returning Men and Women by Hospitals

Efforts are being made to determine the best way of finding employment in hospitals for men and women leaving the services and to permit hospitals, needing specially skilled personnel in various departments, to obtain available individuals from the services.

With respect to pathologists, radiologists, medical superintendents and specialists in various departments, the Canadian Medical Procurement and Assignment Board, Elgin Building, Ottawa, should be contacted. Major J. W. Willard is the Executive Secretary.

As far as nurses are concerned there is no central clearing place for the filing of available positions. However, as nursing sisters must report to the chief matron in each military district upon discharge, positions available could be recorded with the matrons of several of the nearby military districts. It would be well also to have such openings for discharged nurses recorded with the Matron-in-Chief for each service at Ottawa.

Mr. Arthur MacNamara, Deputy Minister of Labour, writes:

"So far as graduates in household economics and such other technical persons as hospitals require (biochemists, bacteriologists, etc.) are concerned, needs in these categories should be filed with the Wartime Bureau of Technical Personnel, either directly by the hospitals to the Bureau in each region or through the Canadian Hospital Council to the National Bureau. The Bureau has contact with rehabilitation officers and employment advisors dealing with service personnel.

"Persons in other categories can be cleared in the normal way through Employment Offices. Records of employment are made available to employment advisors in rehabilitation centres as well as to special veterans' placement officers of the local offices."

### Maritime Blue Cross Changes

The following changes and extension of benefits have been announced by the Maritime Hospital Service Association:

Effective January 1st, 1946, thirty instead of twenty-one days of service will be provided to all participants per contract year.

Effective immediately (August) an enrolment and re-enrolment fee of $1.00 for other than group subscribers will be made. Individual subscribers are accepted only during community campaigns and the object of the $1.00 fee is to discourage individual enrolment but to encourage such applicants to assist towards the end that acceptable groups may be organized in the communities.

Out-patient service in hospitals will now include x-ray to the limit of $10.00, plus usual emergency service for traumatic cases immediately following accident and injury.

Membership on the Board of the Plan is to be made up from three different groups, i.e., member hospitals, the medical profession and subscribers.

# Here and There

## "Patrick of Yorkton"

**One of Saskatchewan's great pioneer doctors was Dr. Thomas Patrick, who started to practise in that province in 1889. Always a colourful and plain-spoken leader among his colleagues, his death two years ago removed one of the most outstanding members of that early group of hardy pioneers. Dr. Edwin Seaborn, historian of the medical school of Western Ontario, has written a vivid sketch of Patrick's career in the unusually fine Anniversary Number of the Historical Bulletin issued by the Calgary Associate Clinic.**

**Drawing partly from Dr. Patrick's own writings and partly from other data, Dr. Seaborn describes the difficulties of travel in those pioneer days. We quote in part only:**

To the traveller the symmetrical position of these stakes (marking quarter sections on the open prairie for prospective homesteaders) revealed his exact location and the direction and the distance to any other point the position of which was known to him. So Dr. Patrick learned at once to find these stakes and to read them. Moreover, on a clear day or night, with observations of the sun, the north star or the planets, with the time shown by his watch, it was easy to orient himself. On a dark day he still might orient himself by looking for several minutes into the darkness of his cap, then quickly removing the cap. The failing light of the sun might be made out as he quickly turned around to detect the point of maximum intensity of the light. If lost on a dark night, there was nothing to do but await the coming of the dawn.

In summer transportation was easy, as one could drive whole days without meeting any obstruction nor altering his course other than to escape passing through a poplar bluff or grassy pool. He was filled with a sense of boundless freedom and well-being as the high clouds modulated the greens of the grasses and the light winds rippled the silver of the lakes, and a sense of security from want was given by the abundance of furry and feathered game.

In the autumn freeze-up and the winter and spring break-up, transportation was difficult and was effected by a combination of gig, buggy, waggon, sleigh or "jumper", by horseback or on snow-shoes, with every adventure that these could give, pitched at some time or another in every direction from everything into everything; sometimes using splints, bandages and adhesive to mend his vehicle rather than the bones for which they were intended. Horses he found differed in many ways, especially in their ability to keep going and in their reactions when they or the vehicle got into trouble. "One good mare I had would make nine miles an hour on end and, when the vehicle overturned or broke down, would watch me while I righted things and be off again at the first chirrup."

"By sleigh or 'jumper' (a handmade sleigh with broad runners) the going was not bad. With heavy underwear throughout, with light and heavy socks, moccasins, long moccasin-leggings, jersey, light cloth coat, heavy fur coat, woolen gloves and fur mittens, wrapped in a heavy buffalo-robe we could drive in comfort; with a good blanket, a sack of oats and a wisp of hay we could rest in comfort; in the shelter of a poplar bluff with pot, pan, dead bark, we could eat and drink in comfort, and with a woven rabbit-skin comforter we could sleep in comfort and so ride out the greatest storm. For we never went unprepared.

"And the miseries of whole days on horseback when one had not ridden for months.

"And on snow-shoes from early dawn into dark night staggering through drifts and floundering in soft snow, feet swollen from the cross pieces and the thongs, joints dislocated by the drag, dizzy and nauseated by the sway, snow-blind in spite of charcoal-blackened face and eyes, to arrive only to recommence after a night made sleepless by the contractions of muscles quivering in pain."

On one occasion, to visit a patient seventy miles away, Dr. Patrick required the services of one railway hand-car and three men, one boat and boatman, two buses, three railway trains, nine men and their nine horses. It took two hours over four days to make the round trip and the cost to Dr. Patrick was ten cents over sixty-six dollars.

Sometimes it was the need of sleep which produced the greatest torments. Sixty miles out and sixty back in one direction, twenty miles in another, too exhausted now to drive himself, his head on the dashboard resting on a pillow, wakened to give directions as to the road to take, seventy miles out and seventy miles back.

Fortunately during the great influenza epidemic of 1918, motor cars could be used. For many months he scarcely ever slept at home, zigzagging from house to house during the whole night. With a "club-car", a mattress and a sleeping bag he was able to lie full length and "get some rest while in motion and much motion while at rest". During the day he attended town cases and unhappily wrote many certificates of death. On one occasion, a man coming many miles to seek aid, reeling and staggering, died with his outstretched hands almost touching the doctor's door.

# Manitoba Medical Centre

## *to be Post-War Project*

THE idea of a Manitoba Medical Centre is fast becoming more than a dream of its enthusiastic projectors. Much spade work has been done by a representative and influential committee and last April an Act to incorporate the Manitoba Medical Centre received provincial assent.

In essence the proposal is to create a great medical centre in Winnipeg which would centralize medical facilities and provide an unexcelled centre for the teaching of medical students and others. The Centre would be located in the area of the present Medical School and the Winnipeg General Hospital.

Already the Central Tuberculosis Clinic, the Cancer Relief and Research Institute, the Psychopathic Hospital and the Provincial Laboratory are located here. The city plans to erect a clinic building in this neighbourhood in the near future. A new and larger building is badly needed by the Children's Hospital and there is said to be a likelihood that the new building may be located at the proposed Centre. St. Joseph's Hospital must enlarge or build a new hospital and the possibility of becoming part of the new Centre is being given serious consideration. The Dominion Government has proposed the erection of a neuro-psychiatric unit which would be the first of its kind in Western Canada. It is suggested, too, that there should be a convalescent hospital (presumably elsewhere) to which could be transferred convalescent patients from the different Centre hospitals.

A strong Board of Governors has been set up representing the city, the university, the Winnipeg General Hospital, the Union of Manitoba Municipalities, the Manitoba Hospital Association, the Department of Health and Public Welfare, St. Joseph's Hospital, the Children's Hospital, the Sanatorium Board of Manitoba, St. Boniface Hospital, the Cancer Relief and Research Institute, the Manitoba Medical Association, the City of St. Boniface and representatives of an Advisory Council authorized in the Act of Incorporation. In all this Board will have thirty-six members. A strong Advisory Council representing a varied group of organizations has already been named. Dr. Harry Coppinger has been named secretary of the Manitoba Medical Centre. A new development is the arrangement for a committee of six, two from the Government of Manitoba, two from the University of Manitoba, and two from the City of Winnipeg to make a study into costs and especially to study the cost differential as between teaching and non-teaching hospitals.

Writing in the June issue of the *Manitoba Medical Review*, Dr. Ross Mitchell, one of Manitoba's leading medical men, urged that the medical profession adopt the idea of a medical centre as a living memorial to the doctors who had given their lives on active service. "What better retribution than to make the noble dream of the Manitoba Medical Centre come true! Living—how they would have delighted in the opportunities of better teaching and increased facilities for research. Dead —how can their memory be kept greener in our minds than by making the plan a reality!"

Dr. Mitchell pointed out that "The Centre will not destroy the autonomy or usefulness of existing hospitals. Medical teaching will continue to be carried on in hospitals outside the Centre. The grouping together, however, of three or more hospitals and institutions in one closely knit space and the creation of a new clinical teaching unit will ensure better training of medical students, nurses and technicians, and greater facilities for the diagnosis and treatment of diseased persons and opportunities for research."

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**Princess Ninaki Graduates**

A full-blooded Indian of the Blood tribe, honoured by her people with princess rank and named "Ninaki" (First Woman), Miss Nora Mary Gladstone was graduated from the Royal Jubilee Hospital at Victoria, B.C., last May.

Miss Gladstone has had an interesting career and has been outstanding among her people. In 1937 she was chosen to represent her people at the coronation of King George VI, travelling to London, England, for the ceremony. On graduation from high school she received a scholarship from the Canadian Mothercraft Society in Toronto, where for two years she specialized in work with children. Following this she entered the school of nursing at the Royal Jubilee.

Her ambition is to take back to her people the knowledge she has

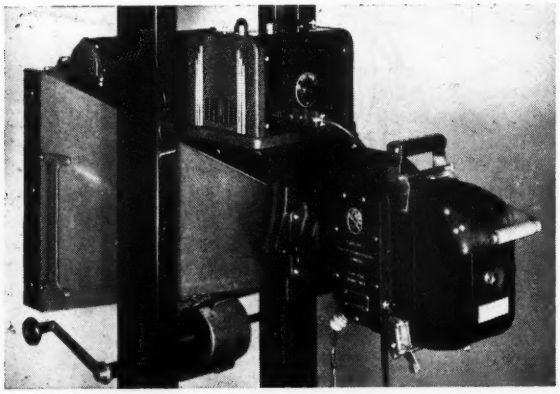
received of the principles of good motherhood and to help in the restoration of the supreme health which they formerly enjoyed.

**Nurses in Army May Get Discharge**

A surplus of nurses in the R.C.A.M.C. following the end of the war and the return to Canada of many nursing sisters who have served overseas has made possible the release of a considerable number of army nurses. Effective at once, any army nursing sister may make application for return to reserve status or retirement.

The following classes of nursing sisters may be retired or returned to reserve status: all married officers, all unmarried officers subject to restricted postings on compassionate grounds, and all officers with a priority release score of 70 or less, provided they have completed a year in the service.

# Fairchild 4″ x 5″ Camera Now Available Through General Electric



The detection of early hidden tuberculosis and other ailments by means of mass radiography will be greatly expedited as a result of a new series of photo-roentgen units announced recently by General Electric X-Ray Corporation, Chicago, adaptable to 70 mm. roll film as well as 4″ x 5″ cut film.

Available with G-E photo-timer, which is based on the Morgan-Hodges principle, the new equipment makes possible the automatic control of the x-ray exposure.

Application of roll film was made practical by the development of a special 70 mm. camera by Fairchild Camera and Instrument Company. Field trials and other forms of investigation showed that an image size which can be placed on a 70 mm. roll film still retains a degree of "diagnostic trust" which recommends it for programmes of mass radiography. The area of each frame on this film is approximately 7 square inches.

The design of the units has been so engineered as to permit the interchangeable use of either the 70 mm. serial camera, the 4″ x 5″ single-exposure film back or the 4″ x 10″ stereo film back, depending on the purpose for which the x-ray is employed. Cut film for example, may be preferred over roll film for radiography of all entering hospital patients since it is easier to remove and handle in processing, where cases are examined individually before being admitted.

Since film employed in this camera has a panchromatic emulsion, it must be processed in total darkness, involving the use of special equipment, the Smith-Fairchild unit, which consists of a light-tight solution tank about 5″ x 11″ x 5″ in size, holding 7 pints of developer.

A motor-driven mechanism passes the film through the solution from one spool to another until the process is completed. After the developer is discarded, the process is repeated with stop-baths, fixing and final washing solutions. This procedure, exclusive of drying, requires about 45 minutes.

### Hamilton Approves Plans for New Hospital

Final plans are being prepared for the new $2,500,000 city hospital on Mount Hamilton, Dr. Miles G. Brown, superintendent of Hamilton General Hospital, has announced.

The project was approved by the ratepayers in a money by-law last December. It is not expected that the new building will be ready for occupancy for two years.

### New Nurses' Home at V. G. H.

Sub-contracts have been awarded for the construction of a nurses' home at the Vancouver General Hospital. The cost of the new construction will amount to $45,900.

## Alden Mills Resigns Post

Mr. Alden B. Mills, who has been managing editor of *The Modern Hospital* for the past twelve years, has resigned to accept a position as superintendent of the Huntington Memorial Hospital, Pasadena, California.

Mr. Mills has long been considered one of the outstanding writers and editors in the hospital field. His book on hospital public relations, published some years ago, quickly became recognized as the leading work on this subject. For many years he has taken an active part in hospital conventions throughout the country and has served on various committees of the American Hospital Association.

Besides taking a very keen interest in hospital affairs, Mr. Mills has shown himself to be a good citizen by taking a leading part in other activities. He is president of the Evanston Council of Social Agencies and president of the Illinois Association of School Boards. He is chairman of the Public School Study Commission, a group of school board members and professional educators formed to produce a series of pamphlets for the education of school board members in Illinois. He is also a member of the 1946 Year Book commission of the American Association of School Administrators.

Mr. Mills takes up his new work in California with the good wishes of all his many friends on both sides of the border.


# Suture Breakage Minimized

## WITH ETHICON'S 20% MORE STRENGTH-UNIFORMITY

• "What is the secret of Ethicon's strength?" we are sometimes asked.

That's a secret we are glad to tell.

*First*—Ethicon manufactures its own surgical gut. Every process from sheep to sterile tube is performed by our own laboratory and technical staff.

*Second*—Special machines, exclusive with Ethicon, designed by our engineers, are capable of polishing the gut to a tolerance of 2/10,000 of an inch.

Tru-Gauging, as this new method is called, results in precise end-to-end size-uniformity and contributes to greater strength-uniformity. Independent laboratory tests confirm that Ethicon Tru-Gauged Catgut has an average strength-uniformity 20% greater than hand-polished gut.

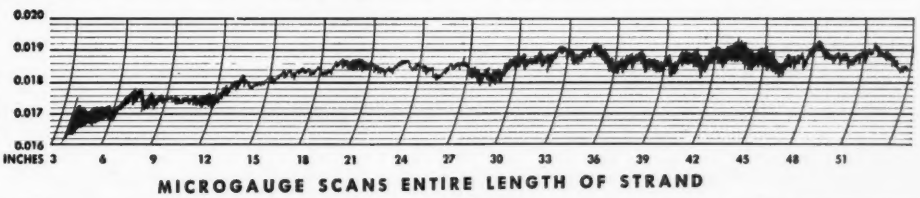
You can minimize breakage annoyance with Ethicon.

Only Ethicon Sutures are Tru-Gauged.

### Photoelectric microgauge tells significant story

**HAND-POLISHED CATGUT, U. S. P.**

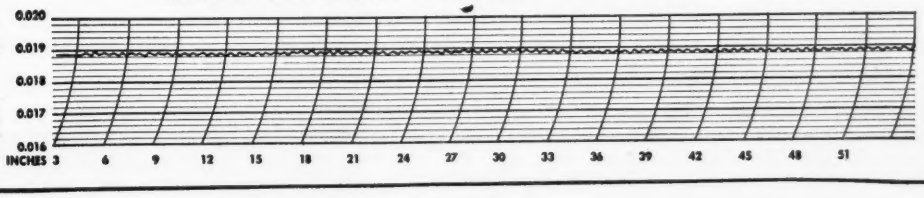
Size 1, charted by photo-electric microgauge, shows diameter irregularities along entire length of strand.




MICROGAUGE SCANS ENTIRE LENGTH OF STRAND

**ETHICON TRU-GAUGED CATGUT, U. S. P.**

Size 1, charted by micro-gauge. Note uniformity. This gives 20% greater *strength*-uniformity.




SUTURE DIVISION

Johnson & Johnson
LIMITED MONTREAL

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ALL STEEL CONSTRUCTION – BAKED ENAMEL FINISH

### No. 7179
### Instrument Cabinet

■ Approximate overall dimensions — 24" wide, 14" deep, and 65" high.

All Steel Welded Construction.

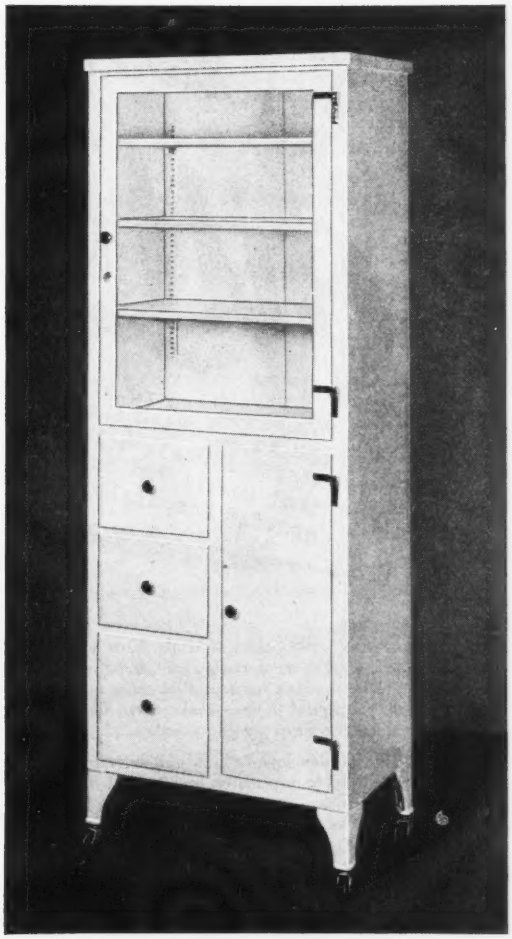
Top Section has three adjustable shelves for instruments, solutions, etc.

Lower Section consists of three spacious drawers and cupboard with shelf, removable but not adjustable. This provides ample space for storage of bandage, tape and towels.

Cabinet is provided with lock on upper section and all hardware is bright nickel plated. Finish is of Metal Craft fine triple coat White Baked Enamel.

Every Institution is in constant need of this excellent storage facility.

This is a fine example of our Metal-Craftsmanship. For over 35 years we have studied, and built your exacting requirements into our product. This experience is at your disposal. We solicit your enquiries for specialized equipment.



The METAL CRAFT CO. LIMITED
GRIMSBY ONTARIO

# War Exchange Tax Still Holds on X-Ray and Laundry Equipment

A number of hospitals have inquired concerning the possibility of having hospital purchases of x-ray apparatus and laundry machinery exempted from the War Exchange Tax, as has been provided when such equipment is purchased by manufacturers. The Canadian Hospital Council has taken this matter up at Ottawa.

It would appear that the exemption of this equipment from the War Exchange Tax is only incidental to the policy of the government to make it easier for manufacturers in Canada to expand their facilities for ready conversion to peacetime activities and the employment of normal labour. Writing to the Secretary of the Council, Finance Minister Ilsley stated on July 18th:

"Throughout the war the principle having the War Exchange Tax apply to all imports has been maintained practically intact, regardless of the class or kind of item being imported. In last year's budget an exception to this rule was made, when an exemption in respect of farm machinery was granted. Recently, on May 10th last, by Order-in-Council, an exemption was granted in respect of industrial machinery and equipment, as a measure to assist in the reconversion of industry to peacetime needs. I did not attempt at that time to deal with all items subject to this tax, but confined action to such items as appeared to warrant emergency measures."

In replying on behalf of the Department of National Revenue, Mr. L. R. Younger stated:

"I would point out that the provisions of paragraph (b) of Order-in-Council P.C. 3408 are quite specific, providing for the war exchange tax exemption of plant equipment as used by a manufacturer in connection with the manufacture or production of goods in Canada.

The Department had no alternative than to rule that equipment for Canadian hospitals is not covered by the exemption and is, therefore, subject to the tax.

You are aware that the powers of this Department are administrative only.

To meet your wishes that the public hospitals of Canada be extended the same exemption now accorded industry would require special legislation."

Mr. Ilsley assured us that this request "will be carefully reviewed when the budget for presentation at the forthcoming session is being prepared".



### Two Leaders Honoured

Mr. Robert Jolly, administrator of Memorial Hospital, Houston, Texas, has had conferred upon him the honorary degree of Doctor of Humanistic Letters by Baylor University. Mr. Jolly has been a prominent figure at conventions of the American Hospital Association, at the A.C.S. Hospital Congress and other gatherings. A past-president of the A.H.A., his Friday morning Round Tables, shared jointly with Dr. MacEachern, have long been a notable feature.

Miss Mary Beard, retired director of the Red Cross nursing service in the United States, was awarded an honorary LL.D. degree at this year's commencement exercises at Smith College.

# Commission Reports Against Winnipeg Cancer Treatment

Another cancer treatment that received wide publicity in the press has not stood the test of impartial scientific investigation. The findings of a four-man commission appointed by the Manitoba Government following a demand for recognition in the House of Commons of the work done by Dr. J. R. Davidson have been released by Health Minister Ivan Schultz.

This Commission was made up of Dr. Alfred Savage, animal pathologist for Manitoba, chairman; Dr. W. L. Mann and Dr. O. C. Trainor, both of Winnipeg, and Dr. A. F. Menzies of Morden.

The Commission's report said "there is no evidence to show any modification of a definitely cancerous growth as a result of his method of treatment". It added that in early cases of cancer, actual or even suspected, the Davidson treatment "most emphatically should not be used instead of methods of proved value".

Dr. Davidson's theory is that cancer is caused by nutritional deficiency and that if parents receive the proper diet before the birth of the child it would go a long way in preventing the development of the disease. His method of treatment is based on a combination of a high vitamin diet with certain biological preparations, including fertilized eggs and a young tissue extract made from new-born rats or mice.

The Commission recommended in the report that no public money be voted to aid further experiments of the general kind carried on by Dr. Davidson unless it be for an extensive and prolonged programme of experimental work conducted by adequate personnel. The need for broad scientific approach to cancer is also recommended by the Commission. Early diagnosis and prompt application of therapeutic measures of proved value are necessary.

An analysis was made of a list of 385 cases willingly supplied by Dr. Davidson, and of these 145 were regarded as cancerous. The analysis showed that of these 145 cases 89 died within six months to five years after starting treatment, and 33 of the remainder who were definitely cancerous all showed extension of the disease after undergoing Dr. Davidson's treatment for periods ranging from less than six months to more than two years.

In a letter submitting the report, the Commission chairman said: "It is also recommended, please, that the findings be not considered as reflecting in any way upon the integrity and good faith of Dr. Davidson."

### Board Approves Plan for New Wing at Kamloops

Work will begin almost immediately on a new west wing and alterations to the existing building of the Royal Inland Hospital, Kamloops, B.C. The cost of the new wing and alterations will amount to $326,386.

# it started a REVOLUTION

THE majority of the great revolutions of history have aided the growth of light and knowledge and resulted in benefits for humanity throughout the world. Of such are the qualities attributed to 'SULFASUXIDINE' *succinylsulfathiazole*—the therapeutic use of which "has revolutionized surgical procedures performed on the colon."[1]

Widely accepted as a drug of choice for bacteriostasis in intestinal surgery, 'SULFASUXIDINE' *succinylsulfathiazole*, because of its high concentration in the intestinal tract, is an exceptionally effective enteric bacteriostatic agent. Blood concentration of the drug is low, because it is poorly absorbed from the bowel, and toxic reactions are negligible.

One study of 50 patients who received 'SULFASUXIDINE' *succinylsulfathiazole* before and after surgery of the intestinal tract indicated that "the postoperative course is unusually smooth, that serious complications due to infection following fecal contamination are largely eliminated, and that the period of hospitalization and convalescence is definitely shortened."[2]

The administration of 'SULFASUXIDINE' *succinylsulfathiazole* is particularly efficient in the treatment of acute or chronic bacillary dysentery[3] as well as its carriers.[4]

The compound also has proved effective in the treatment of other lesions and acute infections of the colon such as ulcerative colitis.[5]

'SULFASUXIDINE' *succinylsulfathiazole* is supplied in 0.5 Gm. tablets in bottles of 100, 500, and 1,000, as well as in powder form (for oral administration) in ¼-pound and 1-pound bottles. **Sharp & Dohme (Canada) Ltd., Toronto 5, Ontario.**

1. Surg. Clinics of N. America, Feb., 1944. 2. J.A.M.A., *120*:265, 1942. 3. J. Lab. & Clin. Med., *28*:162, 1942. 4. J.A.M.A., *119*:615, 1942. 5. Med. Clinics of N. America, *27*:189, Jan., 1943.

## 'SULFASUXIDINE'

*Succinylsulfathiazole*

# Tuberculosis Survey of Ottawa Federal Civil Servants

A survey of the Federal civil servants in Ottawa was done by the Division of Tuberculosis Prevention of the Ontario Department of Health from September 1943 to March 1944. A report on this survey is presented in the July issue of the *Canadian Journal of Public Health*. Films 4" x 5" were taken of all civil servants, checked in Toronto and then 14" x 17" films of all with suspicious shadowing. Physicians in the Division then went to Ottawa to interview and examine all who had been x-rayed. Careful histories and examinations were recorded, including blood sedimentation tests, sputum and chest examinations and tuberculin tests.

**Summary of Findings**

1. One hundred and twenty cases of active tuberculosis were reported among 30,260 Federal civil servants examined.

2. One hundred and thirteen or 94.1 per cent of the cases of active tuberculosis were satisfactorily disposed of.

3. The incidents of active tuberculosis found in this survey, of what might be called a selective group, is 0.39 per cent or roughly four in every thousand people examined. This was three times the average found in other Ontario surveys in 1943.

It is thought that some of the reasons for the high percentage of active cases found in this survey are: (a) the influx of people to the City of Ottawa and district from other Provinces and sections of Ontario where the incidence of tuberculosis is much higher than the average for the Province as a whole; (b) the crowded living conditions in Ottawa; and (c) certain economic factors.

4. Of the 80 newly discovered cases analysed, only 10 per cent had consulted a physician within the past year and a very considerable number gave a history of contact and pleurisy. Also, there were 32 previously known cases which were shown to have become re-activated. It is apparent from these facts that preventive services are inadequate.

5. The Federal civil servants gave every co-operation during the survey.

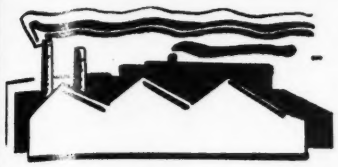
6. This is the largest x-ray survey of a single civilian group in one local area that has been done in Ontario.

---

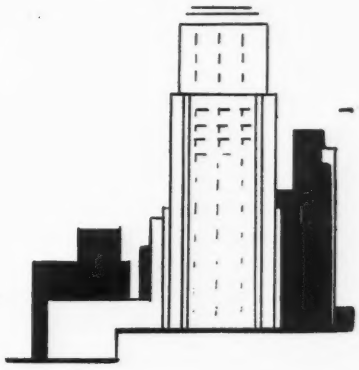
**Neoprene Prices Reduced More for Civilian Uses**

Price reductions averaging 37 per cent on two types of neoprene synthetic rubber and 30 per cent on several other types, have been announced by the Organic Chemicals Division of Canadian Industries Limited.

Improvements in manufacturing methods have stepped up the output to the point where many more civilian requirements for neoprene latex can be met. Superior to natural rubber in its resistance to sunlight, flame, chemicals and oxygen-aging, neoprene has been adopted for many special uses despite being more expensive than natural rubber.

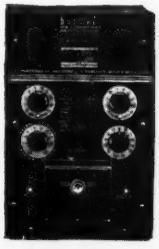


# Your PROPERTIES WILL BENEFIT BY USING DUNHAM DIFFERENTIAL HEATING

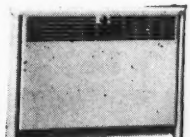


■ Dunham Differential Heating provides the comfort so important to occupants in residential buildings. It also assures balanced heating essential to workers' efficiency in factories and in office buildings. Where different temperatures must be maintained in different parts of the building a controlled heat supply is required in order to balance the varying heat demands. Dunham gives that control. No matter where a building (that requires these standards of heating), is situated, it will benefit from Dunham Differential Heating.

Your properties will also benefit from the economy of Dunham Differential Heating. Economy that results from its low fuel consumption—whether automatically or manually operated — and lower maintenance costs. This unique steam heating system will provide in the buildings under your direction a performance that means profit for you and true heating comfort for the occupants. C. A. Dunham Co., Limited, 1523 Davenport Road, Toronto 4. Offices from Coast to Coast.



Differential System Electrical Resistance Control Panel.



Cabinet Convectors with easily removable front panel.

Radiator Valves.

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**Differential Heating**

• • • Takes on the whole burden of maintaining comfort-level temperatures at all times, in all parts of a building, in all weather conditions, under variables in service and occupancy.

## *True Heating Comfort*

Heat-comfort requires a constant balance of the steam supply against the requirements for warmth. The requirement is variable, the steam supply should likewise be variable, but not intermittent. Only Dunham Differential Heating has the necessary flexibility to fully meet this variable requirement because no other system is capable of a continuous flow, giving a feeling of "warmth" through automatic control of both steam temperatures and steam volume.

*One of a series of advertisements to acquaint owners and operators of commercial, industrial, institutional and apartment buildings, and consulting engineers and architects with Dunham Differential Heating.*

1. How does Dunham Differential Heating differ from other steam systems.
2. Flexible steam gives comfort.
3. An investment not a speculation.
4. Dunham Differential Heating "changes gears" with the weather.
5. Your properties will benefit by using Dunham Differential Heating?
6. Their names and location are legion.

# ANTISEPSIS

## The Essential Attributes

'As a universal antiseptic "Dettol" is 'excellent, as the practitioner can use 'it on the surface, in the wound, and 'also for his instruments.'*

* Wakeley, C.P.G. (1942) *The Practitioner*, 149, 50

This quotation summarises a view that has been repeated in numerous technical reports, scientific papers and textbooks during the past ten years. The reason is worth considering.

It is *not* that 'Dettol' is unique with respect to any single quality regarded as essential, or at least desirable, in antiseptic substances. Thus, it is not alone in being lethal to a diversity of pathogenic bacteria, including *Strep. pyogenes, Staph. aureus, Bact. typhosum* and *Bact. coli;* indeed, tested against these organisms, some antiseptics have higher phenol coefficients. Several substances are available which, like 'Dettol', retain high bactericidal potency in the presence of blood, pus and wound contaminants: some which are non-toxic, even at full bactericidal strength: or are applicable, without causing pain or injury, to raw wounds and surfaces: or do not inhibit the natural processes of repair: or are stable at all clinically desirable temperatures and at all dilutions: or are non-staining, agreeable in use and pleasant to smell.

What *is* special to 'Dettol' is that it combines in very high measure *all* these qualities of an ideal general-purposes antiseptic, and it is to this remarkable combination of properties that 'Dettol' owes its present position as the antiseptic favoured above all others in operating theatres, labour wards, casualty posts, factories and homes throughout the Empire.

For the general practitioner and surgeon, obstetrician and nurse, patient and carrier: for sterilization of the skin, wounds or instruments: for all the contingencies of practice that call for an antiseptic that is effective and safe: for major surgery or minor mishaps —the antiseptic of choice is 'Dettol'.

RECKITT & COLMAN (CANADA) LIMITED, PHARMACEUTICAL DEPARTMENT, MONTREAL

## Arteriosclerosis in Hospitals

The European war is ended, thank God, and with it some of our troubles, we hope. One of the major problems during the war period was the personnel shortage, which was indeed acute at all times, a condition accentuated by the increased patient census, and the resultant congestion in our hospitals. The cessation of hostilities and the release of medical men, nurses and non-professional workers from the Armed Services will at least in a measure help to solve this problem, but others remain with us. Prices of food and other commodities, the rationing of food, etc., will likely remain, while there will be less money in circulation. The necessity of vigilance and economy will be even more essential during the postwar period. In view of this fact, may it be respectfully suggested here that our hospital administrators consider the feasibility of employing a full-time purchasing agent; then the purchasing could be done systematically and scientifically, the goods could be checked as they are delivered, and the packing slip or invoice signed by the agent before sending it in to the accountant's office. It is possible that quite a saving might thus be effected, besides placing the hospital on a better business basis and enabling it to give more efficient service. It may be that a person responsible for the purchasing may find enough time to assist with the personnel problems, which are quite numerous to-day.

May I quote a short paragraph from an article by Miss Mildred Riese, Reg.N., of the American Hospital Association:

"There is a sort of arteriosclerosis that leads to degeneration and decadence in institutions. It comes not necessarily from age but from rigid and petrified customs that prevent growth and adjustment. If institutions can be kept flexible and plastic in habit, they need never grow too old to function well, but constant infusions of new blood are required to keep them young; and sometimes they need to change their structure and relationships to limit their functions, or to purge themselves from selfishness and complacency in order to hold their place, or even to survive."

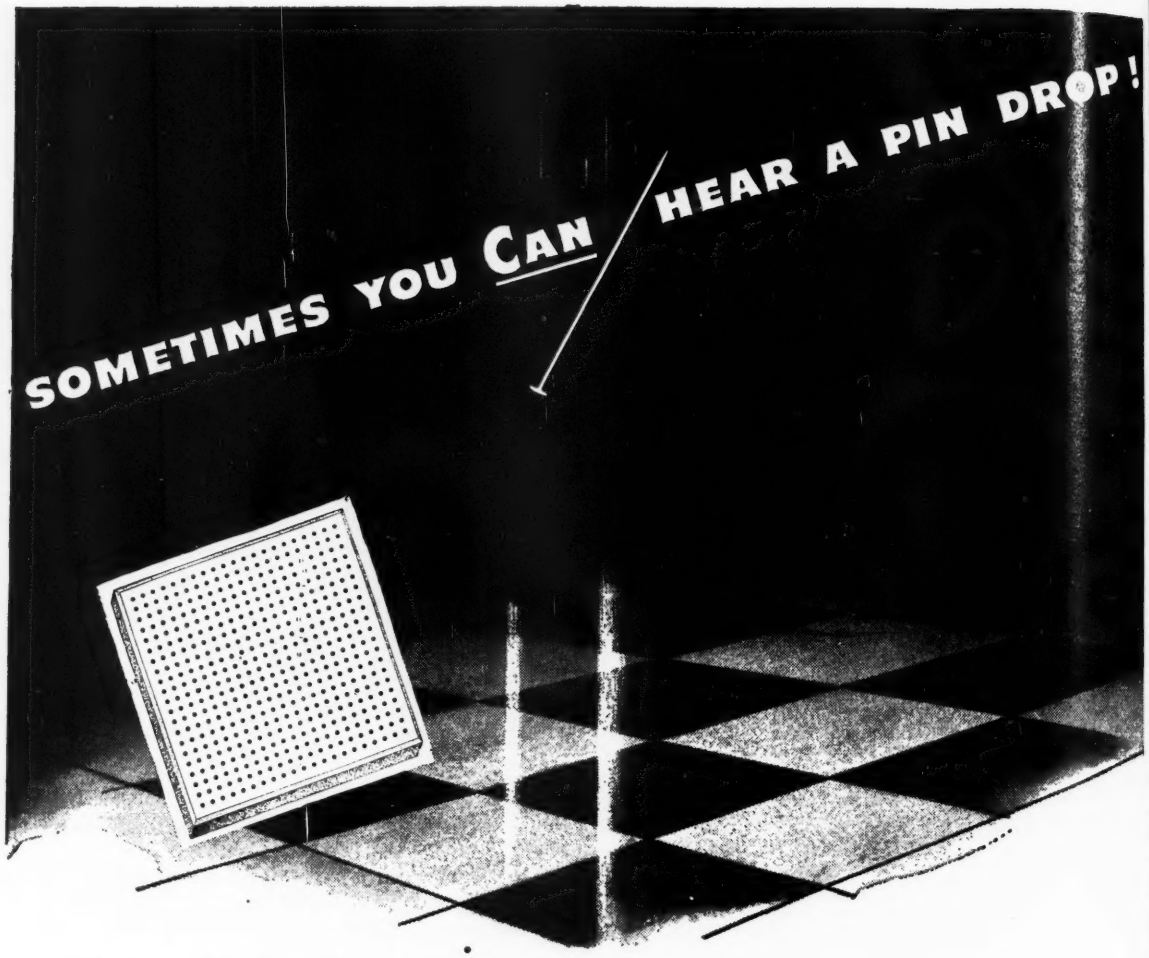
While we all know that this quotation does not apply to hospitals of our Association, it is well for us to keep in mind the possibility of any institution becoming stagnant, thus preventing the growth and the progress which should be more conspicuous in our Catholic hospitals than elsewhere.

*From the Presidential Address by Mother Immaculata, Antigonish, to the Maritime Conference, Catholic Hospital Association.*

### $200,000 Hospital Planned

Tentative plans have been announced for the construction of a new hospital to replace the present Prince Edward County Hospital at Picton, Ontario. The plans call for a $200,000 structure of between 50 and 65 beds. A new site, overlooking the Bay of Quinte, has been suggested.

It has also been suggested that on completion of the new building the present hospital might be used as a convalescent hospital, for which there is increasing need in the district.




*Sound Conditioning with* **ACOUSTI-CELOTEX**

PERFORATED FIBRE TILE—SINCE 1923

IT'S probably the tiniest noise you ever heard and wouldn't annoy a well person. It might not disturb even an invalid. But a hundred and one such little noises, to a sick and feverish patient, can pile up into nerve-jabbing clamor.

Today, there's more noise on every floor. Overcrowding is responsible for a sharp increase in hospital noise. The net result is that recoveries are retarded when they should be hastened . . . overworked staffs are annoyed when they should be calmed.

There's a simple, effective way to convert noise into a gentle hush. Leading hospitals are Sound Conditioning with Acousti-Celotex. In every case the benefits to both patients and staffs have been amazing. Quiet certainly pays big dividends in comfort and efficiency.

Prove it to yourself by quieting one noise source first—a diet kitchen or corridor. Acousti-Celotex, the most widely used acoustical material, can be applied quickly and quietly to ceilings and other surfaces. It can be repeatedly painted without loss of efficiency.

Write to your nearest Dominion Sound dealer for further information.

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Head Office: 1620 Notre Dame Street West, Montreal

BRANCHES AT: HALIFAX TORONTO WINNIPEG REGINA CALGARY VANCOUVER

## The Soap Situation

Effective June 1st, the quota of oils and fats available for soap making has been reduced to 88 per cent of the average figure for the period 1940-41. The reason for this lies in the fact that there is an urgent and heavy demand for oils and fats by the liberated countries of Europe, and since Canada imports most of her oils and fats, she has had to accept the above mentioned cut.

This cut will naturally affect the volume of all types of soaps available for domestic and industrial uses.

It is true that considerable quantities of soap are being manufactured in Canada for UNRRA but it can be definitely stated that oils and fats as well as other supplies needed in the manufacture of soap for UNRRA will be allocated specially for this purpose and that the manufacture of soap in Canada for UNRRA will not be at the expense of supplies for Canadian consumers.

*From "Information", published by the Canadian Research Institute of Launderers and Cleaners.*

The Canadian soap industry will make efforts to maintain the volume of soap production to the pre-June 1st level by the use of builders and soap extenders, but this will not, of course, apply to the type of soap used by commercial laundries which make use of unbuilt soaps in their washing processes.

It will therefore be obvious that commercial laundries should cooperate to the extent of endeavouring to cut down their soap consumption by at least 10 per cent.

We therefore make the suggestions which follow and recommend them for your urgent attention:

(1) Avoid panic buying of laundry soap. The supply is tight, but it is believed that there will be no serious shortage unless users of laundry soap try to build up excessive stocks or use soap carelessly.

(2) Make sure that soap is not being wasted in your washroom—investigate this matter personally if necessary. A good running suds is all that is needed for the washing of cottons.

(3) Give orders to your superintendent for a cut of at least 10 per cent in the amount of soap used. Such a cut can be effected in most plants without appreciably reducing quality.

(4) Make use of short formulas wherever possible.

(5) See to it that your water softener is operating efficiently. Remember that 1,000 gallons of water will use up 1¼ pounds soap for every gram of hardness which the water contains.

---

### Lieut.-Col. K. E. Hollis To Head Sunnybrook

Lieut.-Colonel Karl E. Hollis will be superintendent at Sunnybrook Hospital, the big Veterans' hospital under construction outside Toronto, it has been announced. Lieut.-Col. Hollis, who is a veteran of both world wars, was formerly medical officer commanding the Canadian hospital ship "Lady Nelson".

---

Every individual has a place to fill in the world, and is important in some respect whether he chooses to be so or not.—*Hawthorne.*

## Health Insurance Plan

*(Concluded from page 29)*

government realizes that in calling for general practitioner service in the first stage of the programme it has launched into that phase of health insurance most difficult to appraise actuarially and the one that will lead to most difficulties in administration. The provision of nursing service, desirable though that is also, is one that can lead to endless abuse by patients and may only be controlled by the fact that there is a limit to the number of nurses available. Nursing leaders realize this problem.

No mention is made of the somewhat controversial point as to whether the plan would be operated by a comparatively independent non-political commission representative of the major groups concerned and reporting through the Minister of Health or be subject to the political vicissitudes incidental to being placed directly under the Minister of Health. This point will need to be clarified when details are being developed in the provinces.

Directors and supporters of Blue Cross and other voluntary hospital (and medical) plans will wonder how this will affect them. Will they, in the provinces adopting the plan, be required to limit their benefits to, say, de luxe service, or could they be utilized as a non-profit medium through which the hospital benefits could be arranged?



## Analysis of Hospital Costs

*(Concluded from page 38)*

| *Hospital* | *Visits* | *Cost per Visit* |
|---|---|---|
| Toronto General .... | 74,011 | $1.074 |
| St. Michael's, Toronto ..... | 73,333 | .962 |
| Toronto Western .... | 68,786 | .689 |
| Hospital Sick Children, Toronto ..... | 55,432 | 1.053 |
| Ottawa Civic ..... | 30,759 | .936 |
| Hamilton General.... | 26,636 | .656 |
| Victoria Hospital, London ..... | 21,394 | .914 |
| Women's College, Toronto ..... | 15,855 | 2.138 |
| Hotel Dieu, Kingston ..... | 15,466 | .289 |
| Toronto East General ..... | 13,940 | .649 |
| St. Joseph's, Toronto ..... | 12,196 | 1.560 |
| Brantford General .. | 11,499 | .340 |

Other costs in hospitals with less or occasional patronage ranged from $.012(!) to $3.184 (average for 353 patients).

### Emergency Department

Here again there was a wide variation. The hospital with most patients (St. Michael's Hospital, Toronto), had an average cost of $1.295. The hospitals with the next highest patronage (T.G.H. and T.W.T.) had closely parallel costs $1.291 and $1.786). However, some other hospitals had higher costs. One in Group I was worked out at $8.659 per patient; one in Group I at $7.296 and three in Group IV between $12.051 and $14.782.

### New Hospital Construction

A contract has been awarded for the construction of a 20-bed Municipal Hospital at Mayerthorpe, Alberta. The cost will be $6[illegible]000.

Sub-contracts have been awarded for the construction of a hospital at Willowbunch, Sask. The cost of construction will be $24,790 and the owner is the Willowbunch Union Hospital Board.

## Velyien E. Henderson

Velyien Edward Henderson, M.A., M.B., F.R.S.C., F.R.C.P.(C), professor of pharmacy and pharmacology at the University of Toronto, died suddenly from coronary thrombosis on August 6th at the age of 68. Dr. Henderson was widely known throughout the world for his researches on anaesthetic gases and his discovery of cyclo-propane. He was well known to the medical profession through his long years of teaching, his textbook on materia medica and pharmacy and his chairmanship of the joint committee that worked out the Canadian Formulary. He had been chairman of the Committee on Pharmacy of the Canadian Medical Association at least since 1921, thus making him the dean of its many chairmen. A veteran of the first World War, where he served in France with the C.A.M.C. attached to the 13th Brigade, C.F.A., he has served as chairman of the Federation of American Societies for Experimental Biology and as chairman of the American Society of Pharmacology. At the time of his death he and his C.M.A. committee had just completed a new and up-to-date Canadian Formulary, now in press, designed especially to meet the probable needs under any general plan of health insurance.

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### Medical Care Plans Co-operating with Blue Cross

An August report from the Hospital Service Plan Commission of the A.H.A. reveals that 25 medical and/or surgical plans are now co-ordinated with Blue Cross plans. These medical plans had a combined membership of 1,825,437 on July 1st. Growth during the first six months of 1945 was greater than for the entire year in 1944.

Michigan Medical Service with 842,057 members continues to be the largest Plan. Next largest is that of the California Physicians Service, which has 162,000 members, closely followed by the Massachusetts Medical Service with 153,662.

In Canada there are two medical plans co-ordinated with the Blue Cross Plans. These are the Medical Services Association of British Columbia with 19,050 members and the Manitoba Medical Service with 15,861.

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### $1,000,000 Plant for Grey Nuns

A contract for the construction of a new cancer clinic at the Grey Nuns Hospital at Regina, at a cost of $600,000 has been awarded. Work on the clinic will start immediately.

The clinic is to be in the shape of a cross, four storeys in height, with a basement and will accommodate 152 patients.

Under construction at present is a $160,000 extension to the existing nurses' home which will provide accommodation for 112 nurses.

Also under construction is an addition to the power house at a cost of $60,000. Recently completed was a new laundry, costing $50,000.

Plans of the Grey Nuns hospital call for another extension to be built in the near future to the front of the hospital at a cost of $125,000.

Cost of all structures when completed will be over $1,000,000.

### "Hamonic" Fire

*(Concluded from page 33)*

received a preliminary examination and temporary dressings and 35 had been x-rayed. By 5 p.m. all patients had received a second and more thorough examination, and casualties had been segregated into "in" and "out" patients. By 8 p.m. things were practically back to normal. Some patients had been moved to private homes, some to Polymer Hospital, while others were dispatched to a Red Cross Unit at Blackwell, a distance of about ten miles.

Almost all patients were without clothing. Although the fire first broke out in the freight sheds it spread to the boat so rapidly that most of the passengers barely had time to escape in their night attire. However, on release from the Hospital the Red Cross provided them with enough clothing for street travel, so that they could purchase clothing of their own choosing in the downtown shopping area.

At the time of writing, there are only 9 patients left in the hospital, all of whom fall in the more serious category of major injuries.

It may be of interest to note that the Sarnia General Hospital now uses "Jelonet" as a covering for burns, believing it to be superior to the pre-war tannic acid treatment. The Medical Research Laboratories at Fort Knox, Kentucky, have made many advances with regard to burns, even up to the 6th degree which is caused at 932 degrees Fahrenheit. According to them, many new creams and lotions for burns now on the war secret list will be released for the use of civilians in the near future. Whether it is a simple dressing of petrolatum jelly and a sterile covering with a dusting of sulpha drugs to cut the risk of infection or whether some other method is used, the goal is the same—to apply enough pressure to the area to prevent the leakage of plasma from the body, for it is found that this not only promotes new skin growth but goes a long way towards lessening the need for skin grafts.

### Point System in Reverse

A dispatch from Ottawa states that nearly 3,000 nursing sisters are still serving in the Canadian army, with 1,275 in the European theatre. Discharges are proceeding on a point system exactly opposite to that applied to the soldier. The average nursing sister does not want to leave the service, and those with the lowest number of points are retired, an army official said.

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### 100-bed Memorial Hospital

Plans have been announced for the erection of a 100-bed memorial hospital at Matapedia, in honour of members of the Royal Rifles of Canada who lost their lives at Hong Kong. The land on which the new hospital will be built was donated by the New York Salmon Club.

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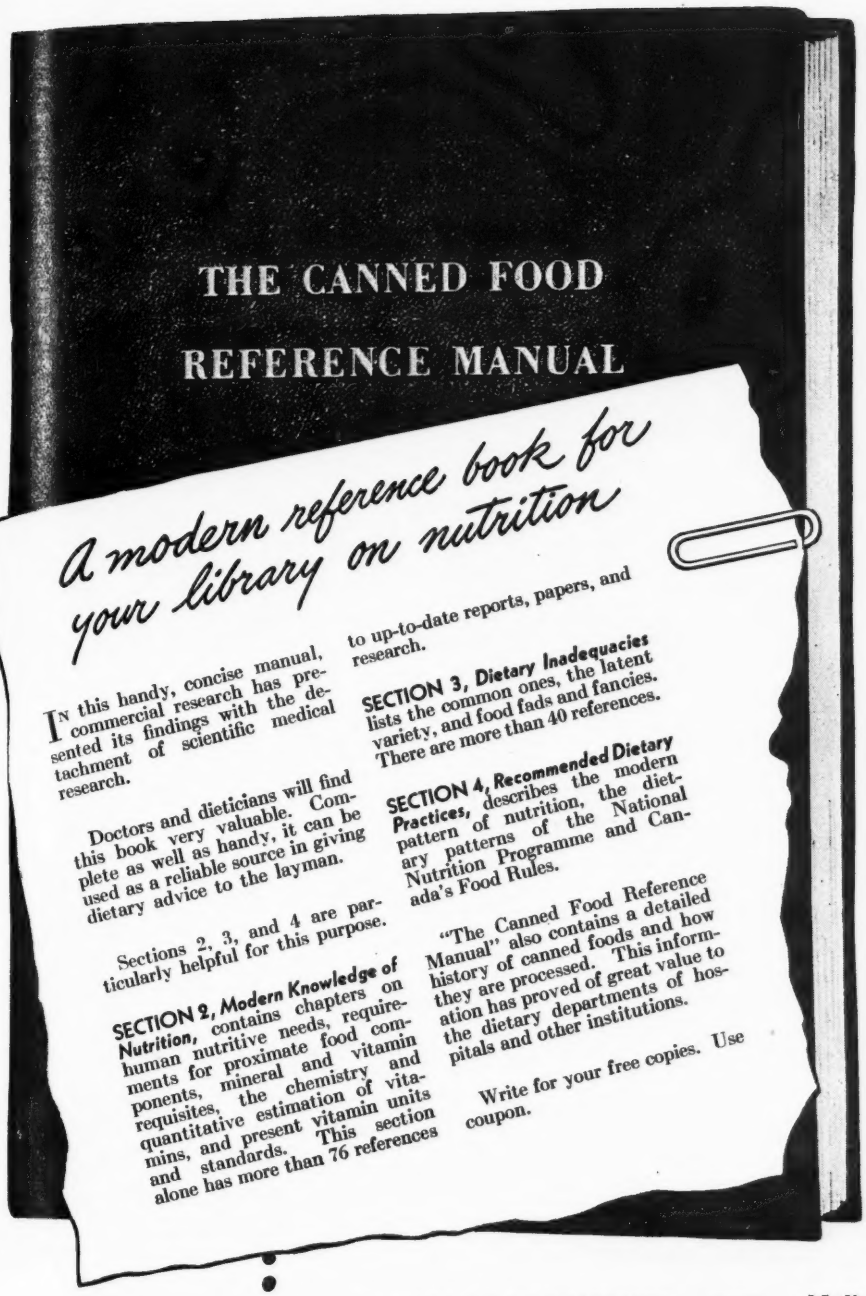
Miss Jean Holt, former assistant superintendent of St. Andrew's Hospital, Midland, Ont., has been appointed superintendent, succeeding Miss Jean Tannahill, who has retired.

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### 18-bed Hospital Opened

The new St. Joseph's General Hospital, Little Current, Ontario, was opened at the end of August. The first floor of the 18-bed hospital contains the large public ward, two semi-private wards, a private ward and a wash-up room. The operating room is located on the second floor. Semi-private rooms are also located on this floor. The upper floor is devoted exclusively to nurses' quarters and a chapel for the Sisters of St. Joseph.

### Suggestions from Administrator

*(Concluded from page 46)*

in our general hospitals. Experience has shown that nurses can and do become infected from undiagnosed, open cases of tuberculosis that happen to be receiving treatment for something else. Hospital authorities should bring to the attention of their medical staffs the necessity of a more thorough physical examination of all patients that may be Tb. suspects. We realize that doctors are busy, but it should be their particular concern to see that no open cases will be admitted to a general hospital to receive treatment and thus to expose to infection those who would unknowingly care for the Tb. patient without observing the precautions ordinarily taken with such patients. A lively interest in this problem on the part of all hospitals and doctors would result in a more widespread investigation and the eventual control of this disease, which is a menace to the health of our nurses as well as that of the public.



### A Nurses' Home

*(Concluded from page 41)*

*corps* which has, in these trying times, been a lifeline to superintendents of nursing. The loyalty of the graduates has been an important factor in maintaining service. Life in the nurses' residence allows a wide range of contact. Living together, enjoying group activities, exchanging ideas and developing tolerance contribute immeasurably to the spirit of the institution. Students themselves enjoy and appreciate the facilities available through a well-directed extra-curricular programme such as can be established *within* a nurses' residence (the need for travelling any distance results in poor participation.)

One of the finer aims in a nurse's training is the creation of a good citizen, not only for a community but for the world. Through the unique contacts in a nurses' residence, the student develops a broad national and international point of view. Universities, too, seem to have recognized this vital force in character building, as the tendency now is towards more student residences on the campus.

#### Conclusion

It will be seen, then, that from both the hospitals' and the nurses' point of view there are *more advantages than disadvantages in the maintenance of a nurse's residence*. Stability, uniformity, discipline and quality of service, are all affected by where and how the nurses live.

Therefore, on the basis of six highly qualified and very decided opinions, we conclude that "The Home", in fact "Our Home", is far superior to "Anybody's Home".

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